Assembly Bill No. 1515

Passed the Assembly August 24, 2015

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Chief Clerk of the Assembly

Passed the Senate August 20, 2015

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Secretary of the Senate

This bill was received by the Governor this _____ day of _____, 2015, at _____ o'clock ___M.

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Private Secretary of the Governor

CHAPTER _____

An act to amend Sections 739.3, 922.41 1729.2, 1861.02, 1861.025, 10111.2, 10127.13, 10232.3, 10235.35, 12418.4, and 12921 of, to amend, repeal, and add Sections 510, 742.34, 790.034, 1725.5, 1764.1, 10169, 10192.18, and 12820 of, and to repeal Section 10233.9 of, the Insurance Code, and to amend Section 1299.04 of the Penal Code, relating to insurance.

LEGISLATIVE COUNSEL'S DIGEST

AB 1515, Committee on Insurance. Insurance.

(1) Existing law requires certain insurance disclosures in various circumstances, including, but not limited to, when a life or disability insurance policy or certificate of coverage is first issued or delivered to a new insured or policyholder, when an employer obtains coverage from a multiple employer welfare arrangement, when a claim is up for settlement, and when a vehicle service contract form is offered.

This bill, commencing January 1, 2017, would generally require those disclosures to also include the Department of Insurance's Internet Web site.

(2) Existing law defines the term "Adjusted RBC Report" as a Risk-Based Capital (RBC) report that has been adjusted by the Insurance Commissioner in accordance with specified provisions governing the determination of a property and casualty insurer's RBC. Existing law requires the filing of an RBC report by a life or health insurer if the insurer has a Total Adjusted Capital that is greater than or equal to its Company Action Level RBC but the Total Adjusted Capital is less than the product of its Authorized Control Level RBC and 2.5.

This bill would require the RBC report if the Total Adjusted Capital is less than the product of its Authorized Control Level RBC and 3.0.

(3) Existing law requires every insurer doing business in this state to make and file with the Insurance Commissioner financial statements exhibiting its condition and affairs as of the previous year. Existing law, until January 1, 2016, requires that credit be allowed for a domestic insurer when the reinsurance is ceded to

an assuming insurer that has been certified by the commissioner as a reinsurer in this state and secures its obligations in accordance with certain requirements, as specified.

This bill would extend the above-described credit allowed for a domestic insurer until January 1, 2021.

(4) Existing law provides requirements for a licensee to include certain information on a business card.

Commencing July 1, 2016, this bill would modify the required information as specified.

(5) Existing law provides requirements for various written insurance-related documents, including, among other things, the requirement on all individual life insurance policies and individual annuity contracts to be in certain font and an outline of coverage for long-term care insurance policies.

This bill would modify the requirements with respect to those written documents, as specified.

(6) Existing law requires an applicant or licensee to update his or her application if background information that was provided in the application for a license changes.

This bill would expand the definition of a license to include, among others, title insurance.

(7) This bill would make technical, nonsubstantive changes to correct obsolete cross-references and would delete obsolete provisions.

(8) Existing law, governing life and disability insurance, provides, among other things, that the only measure of insurer liability and damage is the sum payable to the insured in the manner and at the times as provided in the policy. Existing law requires, in addition, if any insurer fails to pay any benefits under a policy of disability income insurance, as defined, within 30 calendar days after the insurer has received all information needed to determine liability and has determined that liability exists, any delayed payment to bear interest, as specified.

This bill would specify that the above requirement to pay interest does not apply to health insurance, as defined.

(9) Existing law provides that any insurer offering long-term care insurance shall provide to the Department of Insurance a copy of the specimen individual policy form or group master policy and certificate forms, corresponding outline of coverage, and representative advertising materials to be used in the state.

This bill would eliminate that requirement.

(10) Existing law provides various procedural rights for, and requirements of, a title insurance representative applicant.

This bill would add the requirement to immediately notify the commissioner, using an approved method, of any change in email, other personal information, or other background information.

(11) Existing law requires the Insurance Commissioner to perform all duties imposed upon him or her by the Insurance Code and other laws regulating the business of insurance in this state and to enforce the execution of those provisions and laws. In an administrative action to enforce the Insurance Code and other laws regulating the business of insurance in this state, any settlement is subject to various requirements, including that the commissioner may delegate the power to negotiate the terms and conditions of a settlement, but shall not delegate the power to approve the settlement.

This bill would authorize the commissioner to delegate the power to negotiate a settlement to designated deputy commissioners, and to delegate the power to approve settlements that do not involve an insurer, a managing general agent or production agent that manages the business of an insurer, a title company, a home protection company, an insurance adjuster whose claims practices are at issue, and an insurance agent or broker, or an insurance agent or broker applicant, who has allegedly engaged in theft, fraud, or the misappropriation of premium or other funds in an amount that exceeds $50,000.

(12) Existing law requires a licensed bail agent, bail permittee, or bail solicitor who engages, in the arrest of a defendant to satisfy specified requirements, including, among other things, the completion of 20 hours of classroom education pertinent to the duties and responsibilities of a bail licensee.

This bill would require a bail fugitive recovery person licensed after December 31, 2012, to have at least 20 hours of classroom prelicensing education, and a bail fugitive recovery person licensed between January 1, 1994, and December 31, 2012, to have at least 12 hours of classroom prelicensing education. The bill would provide that a person licensed prior to January 1, 1994, has no prelicensing education requirement.

The people of the State of California do enact as follows:

SECTION 1. Section 510 of the Insurance Code is amended to read:

510. (a) Whenever a policy of insurance specified in Section 660 or 675, a policy of life insurance as defined in Section 101, a policy of disability insurance as defined in Section 106, or a certificate of coverage as defined in Section 10270.6, is first issued to or delivered to a new insured or a new policyholder in this state, the insurer shall include a written disclosure containing the name, address, and toll-free telephone number of the unit within the Department of Insurance that deals with consumer affairs. The telephone number shall be the same as that provided to consumers under Section 12921.1. The disclosure shall be printed in large, boldface type.

The disclosure shall also contain the address and customer service telephone number of the insurer, or the address and customer service telephone number of the agent or broker of record, or all of those addresses and telephone numbers. All addresses and telephone numbers for the insurer or the agent or broker of record shall be prominently displayed, in boldfaced type. The disclosure shall also contain a statement that the Department of Insurance should be contacted only after discussions with the insurer, or its agent or other representative, or both, have failed to produce a satisfactory resolution to the problem. If the policy or certificate was issued or delivered by an agent or broker, the disclosure shall specifically advise the insured to contact his or her agent or broker for assistance.

(b) This section shall remain in effect only until January 1, 2017, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2017, deletes or extends that date.

SEC. 2. Section 510 is added to the Insurance Code, to read:

510. (a) Whenever a policy of insurance specified in Section 660 or 675, a policy of life insurance as defined in Section 101, a policy of disability insurance as defined in Section 106, or a certificate of coverage as defined in Section 10270.6, is first issued to or delivered to a new insured or a new policyholder in this state, the insurer shall include a written disclosure containing the name, address, toll-free telephone number, and Internet Web site of the unit within the Department of Insurance that deals with consumer

affairs. The telephone number shall be the same as that provided to consumers under Section 12921.1. The disclosure shall be printed in large, boldface type.

The disclosure shall also contain the address and customer service telephone number of the insurer, or the address and customer service telephone number of the agent or broker of record, or all of those addresses and telephone numbers. All addresses and telephone numbers for the insurer or the agent or broker of record shall be prominently displayed, in boldfaced type. The disclosure shall also contain a statement that the Department of Insurance should be contacted only after discussions with the insurer, or its agent or other representative, or both, have failed to produce a satisfactory resolution to the problem. If the policy or certificate was issued or delivered by an agent or broker, the disclosure shall specifically advise the insured to contact his or her agent or broker for assistance.

(b) This section shall become operative on January 1, 2017.

SEC. 3. Section 739.3 of the Insurance Code is amended to read:

739.3. (a) "Company Action Level Event" means any of the following events:

(1) The filing of an RBC Report by an insurer that indicates any of the following:

(A) The insurer's Total Adjusted Capital is greater than or equal to its Regulatory Action Level RBC but less than its Company Action Level RBC.

(B) If a life or health insurer, the insurer has Total Adjusted Capital that is greater than or equal to its Company Action Level RBC but less than the product of its Authorized Control Level RBC and 3.0, and has a negative trend.

(C) If a property and casualty insurer, the insurer has Total Adjusted Capital that is greater than or equal to its Company Action Level RBC but less than the product of its Authorized Control Level RBC and 3.0, and triggers the trend test determined in accordance with the trend test calculation included in the Property and Casualty RBC instructions.

(2) The notification by the commissioner to the insurer of an Adjusted RBC Report that indicates the event in paragraph (1), provided that the insurer does not challenge the Adjusted RBC Report under Section 739.7.

(3) If the insurer challenges, under Section 739.7, an Adjusted RBC Report that indicates the event in paragraph (1), the notification by the commissioner to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge.

(b) In the event of a Company Action Level Event, the insurer shall prepare and submit to the commissioner a comprehensive financial plan that shall do all of the following:

(1) Identify the conditions in the insurer that contribute to the Company Action Level Event.

(2) Contain proposals of corrective actions that the insurer intends to take and would be expected to result in the elimination of the Company Action Level Event.

(3) Provide projections of the insurer's financial results in the current year and at least the four succeeding years, both in the absence of proposed corrective actions and giving effect to the proposed corrective actions, including projections of statutory operating income, net income, capital, or surplus, or a combination. The projections for both new and renewal business may include separate projections for each major line of business and separately identify each significant income, expense, and benefit component.

(4) Identify the key assumptions impacting the insurer's projections and the sensitivity of the projections to the assumptions.

(5) Identify the quality of, and problems associated with, the insurer's business, including, but not limited to, its assets, anticipated business growth and associated surplus strain, extraordinary exposure to risk, mix of business, and use of reinsurance in each case, if any.

(c) The RBC Plan shall be submitted as follows:

(1) Within 45 days of the Company Action Level Event.

(2) If the insurer challenges an Adjusted RBC Report pursuant to Section 739.7, within 45 days after notification to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge.

(d) Within 60 days after the submission by an insurer of an RBC Plan to the commissioner, the commissioner shall notify the insurer whether the RBC Plan shall be implemented or is, in the judgment of the commissioner, unsatisfactory. If the commissioner determines that the RBC Plan is unsatisfactory, the notification to the insurer shall set forth the reasons for the determination, and may set forth proposed revisions that will render the RBC Plan

satisfactory, in the judgment of the commissioner. Upon notification from the commissioner, the insurer shall prepare a Revised RBC Plan, which may incorporate by reference revisions proposed by the commissioner, and shall submit the Revised RBC Plan to the commissioner as follows:

(1) Within 45 days after the notification from the commissioner.

(2) If the insurer challenges the notification from the commissioner under Section 739.7, within 45 days after a notification to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge.

(e) In the event of a notification by the commissioner to an insurer that the insurer's RBC Plan or Revised RBC Plan is unsatisfactory, the commissioner may, at his or her discretion, subject to the insurer's right to a hearing under Section 739.7, specify in the notification that the notification constitutes a Regulatory Action Level Event.

(f) Every domestic insurer that files an RBC Plan or Revised RBC Plan with the commissioner shall file a copy of the RBC Plan or Revised RBC Plan with the insurance commissioner in any state in which the insurer is authorized to do business if both of the following apply:

(1) That state has an RBC provision substantially similar to subdivision (a) of Section 739.8.

(2) The insurance commissioner of that state has notified the insurer of its request for the filing in writing, in which case the insurer shall file a copy of the RBC Plan or Revised RBC Plan in that state no later than the later of:

(A) Fifteen days after the receipt of notice to file a copy of its RBC Plan or Revised RBC Plan with the state.

(B) The date on which the RBC Plan or Revised RBC Plan is filed under subdivision (c) of Section 739.7.

SEC. 4. Section 742.34 of the Insurance Code is amended to read:

742.34. (a) The following notice shall be provided to employers and employees who obtain coverage from a multiple employer welfare arrangement:

"NOTICE

(A) THE MULTIPLE EMPLOYER WELFARE ARRANGEMENT IS NOT AN INSURANCE COMPANY AND DOES NOT PARTICIPATE IN ANY OF THE GUARANTEE FUNDS CREATED BY CALIFORNIA LAW. THEREFORE, THESE FUNDS WILL NOT PAY YOUR CLAIMS OR PROTECT YOUR ASSETS IF A MULTIPLE EMPLOYER WELFARE ARRANGEMENT BECOMES INSOLVENT AND IS UNABLE TO MAKE PAYMENTS AS PROMISED.

(B) THE HEALTH CARE BENEFITS THAT YOU HAVE PURCHASED OR ARE APPLYING TO PURCHASE ARE BEING ISSUED BY A MULTIPLE EMPLOYER WELFARE ARRANGEMENT THAT IS LICENSED BY THE STATE OF CALIFORNIA.

(C) FOR ADDITIONAL INFORMATION ABOUT THE MULTIPLE EMPLOYER WELFARE ARRANGEMENT YOU SHOULD ASK QUESTIONS OF YOUR TRUST ADMINISTRATOR OR YOU MAY CONTACT THE CALIFORNIA DEPARTMENT OF INSURANCE AT _____."

(b) Each multiple employer welfare arrangement should include the department's current "800" consumer service telephone number in the blank provided in paragraph (C) of this notice.

(c) This section shall remain in effect only until January 1, 2017, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2017, deletes or extends that date.

SEC. 5. Section 742.34 is added to the Insurance Code, to read:

742.34. (a) The following notice shall be provided to employers and employees who obtain coverage from a multiple employer welfare arrangement:

"NOTICE

(A) THE MULTIPLE EMPLOYER WELFARE ARRANGEMENT IS NOT AN INSURANCE COMPANY AND DOES NOT PARTICIPATE IN ANY OF THE GUARANTEE FUNDS CREATED BY CALIFORNIA LAW. THEREFORE, THESE FUNDS WILL NOT PAY YOUR CLAIMS OR PROTECT YOUR ASSETS IF A MULTIPLE EMPLOYER

WELFARE ARRANGEMENT BECOMES INSOLVENT AND IS UNABLE TO MAKE PAYMENTS AS PROMISED.

(B) THE HEALTH CARE BENEFITS THAT YOU HAVE PURCHASED OR ARE APPLYING TO PURCHASE ARE BEING ISSUED BY A MULTIPLE EMPLOYER WELFARE ARRANGEMENT THAT IS LICENSED BY THE STATE OF CALIFORNIA.

(C) FOR ADDITIONAL INFORMATION ABOUT THE MULTIPLE EMPLOYER WELFARE ARRANGEMENT YOU SHOULD ASK QUESTIONS OF YOUR TRUST ADMINISTRATOR OR YOU MAY CONTACT THE CALIFORNIA DEPARTMENT OF INSURANCE AT _____."

(b) Each multiple employer welfare arrangement should include the department's current "800" consumer service telephone number and Internet Web site in the blank provided in paragraph (C) of this notice.

(c) This section shall become operative on January 1, 2017.

SEC. 6. Section 790.034 of the Insurance Code is amended to read:

790.034. (a) Regulations adopted by the commissioner pursuant to this article that relate to the settlement of claims shall take into consideration settlement practices by classes of insurers.

(b) (1) Upon receiving notice of a claim, every insurer shall immediately, but no more than 15 calendar days after receipt of the claim, provide the insured with a legible reproduction of subdivisions (h) and (i) of Section 790.03 along with a written notice containing the following language in at least 10-point type:

"In addition to Section 790.03 of the Insurance Code, Fair Claims Settlement Practices Regulations govern how insurance claims must be processed in this state. These regulations are available at the Department of Insurance Internet Web site, www.insurance.ca.gov. You may also obtain a copy of this law and these regulations free of charge from this insurer."

(2) Every insurer shall provide, when requested orally or in writing by an insured, a legible reproduction of Section 790.03 of the Insurance Code and copies of Sections 2695.5, 2695.7, 2695.8, and 2695.9 of Subchapter 7.5 of Chapter 5 of Title 10 of the California Code of Regulations, unless the regulations are

inapplicable to that class of insurer. This law and these regulations shall be provided to the insured within 15 calendar days of request.

(3) The provisions of this subdivision shall apply to all insurers except for those that are licensed pursuant to Chapter 1 (commencing with Section 12340) of Part 6 of Division 2, with respect to policies and endorsements described in Section 790.031.

(c) This section shall remain in effect only until January 1, 2017, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2017, deletes or extends that date.

SEC. 7. Section 790.034 is added to the Insurance Code, to read:

790.034. (a) Regulations adopted by the commissioner pursuant to this article that relate to the settlement of claims shall take into consideration settlement practices by classes of insurers.

(b) (1) Upon receiving notice of a claim, every insurer shall immediately, but no more than 15 calendar days after receipt of the claim, provide the insured with a legible reproduction of subdivisions (h) and (i) of Section 790.03 along with a written notice containing the following language in at least 10-point type:

"In addition to Section 790.03 of the Insurance Code, Fair Claims Settlement Practices Regulations govern how insurance claims must be processed in this state. These regulations are available at the Department of Insurance Internet Web site, www.insurance.ca.gov, or by calling the department's consumer information line at 1-800-927-HELP(4357). You may also obtain a copy of this law and these regulations free of charge from this insurer."

(2) Every insurer shall provide, when requested orally or in writing by an insured, a legible reproduction of Section 790.03 of the Insurance Code and copies of Sections 2695.5, 2695.7, 2695.8, and 2695.9 of Subchapter 7.5 of Chapter 5 of Title 10 of the California Code of Regulations, unless the regulations are inapplicable to that class of insurer. This law and these regulations shall be provided to the insured within 15 calendar days of request.

(3) The provisions of this subdivision shall apply to all insurers except for those that are licensed pursuant to Chapter 1 (commencing with Section 12340) of Part 6 of Division 2, with respect to policies and endorsements described in Section 790.031.

(c) This section shall become operative on January 1, 2017.

SEC. 8. Section 922.41 of the Insurance Code is amended to read:

922.41. (a) Credit shall be allowed a domestic insurer when the reinsurance is ceded to an assuming insurer that has been certified by the commissioner as a reinsurer in this state and secures its obligations in accordance with the requirements of this section. Credit shall be allowed at all times for which statutory financial statement credit for reinsurance is claimed under this section. The credit allowed shall be based upon the security held by or on behalf of the ceding insurer in accordance with a rating assigned to the certified reinsurer by the commissioner. The security shall be in a form consistent with this section, any regulations promulgated by the commissioner, and Section 922.5.

(b) In order to be eligible for certification, the assuming insurer shall meet the following requirements:

(1) The assuming insurer shall be domiciled and licensed to transact insurance or reinsurance in a qualified jurisdiction, as determined by the commissioner pursuant to subdivisions (f) and (g).

(2) The assuming insurer shall maintain minimum capital and surplus, or its equivalent, in an amount to be determined by the commissioner, but no less than two hundred fifty million dollars ($250,000,000) calculated in accordance with paragraph (4) of subdivision (f) of this section or Section 922.5. This requirement may also be satisfied by an association including incorporated and individual unincorporated underwriters having minimum capital and surplus equivalents (net of liabilities) of at least two hundred fifty million dollars ($250,000,000) and a central fund containing a balance of at least two hundred fifty million dollars ($250,000,000).

(3) The assuming insurer shall maintain financial strength ratings from two or more rating agencies deemed acceptable by the commissioner. These ratings shall be based on interactive communication between the rating agency and the assuming insurer and shall not be based solely on publicly available information. These financial strength ratings will be one factor used by the commissioner in determining the rating that is assigned to the assuming insurer. Acceptable rating agencies include the following:

(A) Standard & Poor’s.

(B) Moody's Investors Service.

(C) Fitch Ratings.

(D) A.M. Best Company.

(E) Any other nationally recognized statistical rating organization.

(4) The assuming insurer shall agree to submit to the jurisdiction of this state, appoint the commissioner or a designated attorney in this state as its agent for service of process in this state, and agree to provide security for 100 percent of the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers if it resists enforcement of a final United States judgment.

(5) The assuming insurer shall agree to meet applicable information filing requirements as determined by the commissioner, both with respect to an initial application for certification and on an ongoing basis.

(6) The certified reinsurer shall comply with any other requirements deemed relevant by the commissioner.

(c) (1) If an applicant for certification has been certified as a reinsurer in a National Association of Insurance Commissioners (NAIC) accredited jurisdiction, the commissioner may defer to that jurisdiction's certification, and has the discretion to defer to the rating assigned by that jurisdiction if the assuming insurer submits a properly executed Form CR-1 (as published on the department's Internet Web site), and such additional information as the commissioner requires. The commissioner, however, may perform an independent review and determination of any applicant. The assuming insurer shall then be considered to be a certified reinsurer in this state.

(2) If the commissioner defers to a certification determination by another state, any change in the certified reinsurer's status or rating in the other jurisdiction shall apply automatically in this state as of the date it takes effect in the other jurisdiction unless the commissioner otherwise determines. The certified reinsurer shall notify the commissioner of any change in its status or rating within 10 days after receiving notice of the change.

(3) The commissioner may withdraw recognition of the other jurisdiction's rating at any time and assign a new rating in accordance with subdivision (h).

(4) The commissioner may withdraw recognition of the other jurisdiction's certification at any time, with written notice to the

certified reinsurer. Unless the commissioner suspends or revokes the certified reinsurer's certification in accordance with this section and Section 922.42, the certified reinsurer's certification shall remain in good standing in this state for a period of three months, which shall be extended if additional time is necessary to consider the assuming insurer's application for certification in this state.

(d) An association, including incorporated and individual unincorporated underwriters, may be a certified reinsurer. In order to be eligible for certification, in addition to satisfying requirements of subdivision (b), the reinsurer shall meet all of the following requirements:

(1) The association shall satisfy its minimum capital and surplus requirements through the capital and surplus equivalents (net of liabilities) of the association and its members, which shall include a joint central fund that may be applied to any unsatisfied obligation of the association or any of its members, in an amount determined by the commissioner to provide adequate protection.

(2) The incorporated members of the association shall not be engaged in any business other than underwriting as a member of the association and shall be subject to the same level of regulation and solvency control by the association's domiciliary regulator as are the unincorporated members.

(3) Within 90 days after its financial statements are due to be filed with the association's domiciliary regulator, the association shall provide to the commissioner an annual certification by the association's domiciliary regulator of the solvency of each underwriter member or, if a certification is unavailable, financial statements, prepared by independent public accountants, of each underwriter member of the association.

(e) (1) The commissioner shall post notice on the department's Internet Web site promptly upon receipt of any application for certification, including instructions on how members of the public may respond to the application. The commissioner shall not take final action on the application until at least 30 days after posting the notice required by this subdivision.

(2) The commissioner shall issue written notice to an assuming insurer that has made application and has been approved as a certified reinsurer. Included in that notice shall be the rating assigned the certified reinsurer in accordance with subdivision (h).

The commissioner shall publish a list of all certified reinsurers and their ratings.

(f) The certified reinsurer shall agree to meet applicable information filing requirements as determined by the commissioner, both with respect to an initial application for certification and on an ongoing basis. All information submitted by certified reinsurers that is not otherwise public information subject to disclosure shall be exempted from disclosure under Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code, and shall be withheld from public disclosure. The applicable information filing requirements are as follows:

(1) Notification within 10 days of any regulatory actions taken against the certified reinsurer, any change in the provisions of its domiciliary license or any change in rating by an approved rating agency, including a statement describing those changes and the reasons for those changes.

(2) Annually, Form CR-F or CR-S, as applicable pursuant to the instructions published on the department's Internet Web site.

(3) Annually, the report of the independent auditor on the financial statements of the insurance enterprise, on the basis described in paragraph (4).

(4) Annually, audited financial statements, (audited United States Generally Accepted Accounting Principles basis, if available, audited International Financial Reporting Standards basis statements are allowed, but must include an audited footnote reconciling equity and net income to a United States Generally Accepted Accounting Principles basis, or, with the written permission of the commissioner, audited International Financial Reporting Standards statements with reconciliation to United States Generally Accepted Accounting Principles certified by an officer of the company), regulatory filings, and actuarial opinion (as filed with the certified reinsurer's supervisor). Upon the initial certification, audited financial statements for the last three years filed with the certified reinsurer's supervisor.

(5) At least annually, an updated list of all disputed and overdue reinsurance claims regarding reinsurance assumed from United States domestic ceding insurers.

(6) A certification from the certified reinsurer's domestic regulator that the certified reinsurer is in good standing and

maintains capital in excess of the jurisdiction's highest regulatory action level.

(7) Any other information that the commissioner may reasonably require.

(g) If the commissioner certifies a non-United States domiciled insurer, the commissioner shall create and publish a list of qualified jurisdictions, under which an assuming insurer licensed and domiciled in that jurisdiction is eligible to be considered for certification by the commissioner as a certified reinsurer.

(1) In order to determine whether the domiciliary jurisdiction of a non-United States assuming insurer is eligible to be recognized as a qualified jurisdiction, the commissioner shall evaluate the appropriateness and effectiveness of the reinsurance supervisory system of the jurisdiction, both initially and on an ongoing basis, and consider the rights, benefits, and the extent of reciprocal recognition afforded by the non-United States jurisdiction to reinsurers licensed and domiciled in the United States. The commissioner shall determine the appropriate process for evaluating the qualifications of those jurisdictions. Prior to its listing, a qualified jurisdiction shall agree in writing to share information and cooperate with the commissioner with respect to all certified reinsurers domiciled within that jurisdiction. A jurisdiction may not be recognized as a qualified jurisdiction if the commissioner has determined that the jurisdiction does not adequately and promptly enforce final United States judgments and arbitration awards. Additional factors may be considered in the discretion of the commissioner, including, but not limited to, the following:

(A) The framework under which the assuming insurer is regulated.

(B) The structure and authority of the domiciliary regulator with regard to solvency regulation requirements and financial surveillance.

(C) The substance of financial and operating standards for assuming insurers in the domiciliary jurisdiction.

(D) The form and substance of financial reports required to be filed or made publicly available by reinsurers in the domiciliary jurisdiction and the accounting principles used.

(E) The domiciliary regulator's willingness to cooperate with United States regulators in general and the commissioner in particular.

(F) The history of performance by assuming insurers in the domiciliary jurisdiction.

(G) Any documented evidence of substantial problems with the enforcement of final United States judgments in the domiciliary jurisdiction.

(H) Any relevant international standards or guidance with respect to mutual recognition of reinsurance supervision adopted by the International Association of Insurance Supervisors or a successor organization.

(I) Any other matters deemed relevant by the commissioner.

(2) The commissioner shall consider the list of qualified jurisdictions published through the NAIC committee process in determining qualified jurisdictions. The commissioner may include on the list published pursuant to this section any jurisdiction on the NAIC list of qualified jurisdictions or on any equivalent list of the United States Treasury.

(3) If the commissioner approves a jurisdiction as qualified that does not appear on either the NAIC list of qualified jurisdictions, or the United States Treasury list, the commissioner shall provide thoroughly documented justification in accordance with criteria to be developed under this section.

(4) United States jurisdictions that meet the requirements for accreditation under the NAIC financial standards and accreditation program shall be recognized as qualified jurisdictions.

(5) If a certified reinsurer's domiciliary jurisdiction ceases to be a qualified jurisdiction, the commissioner has the discretion to suspend the reinsurer's certification indefinitely, in lieu of revocation.

(h) The commissioner shall assign a rating to each certified reinsurer, giving due consideration to the financial strength ratings that have been assigned by rating agencies deemed acceptable to the commissioner pursuant to this section. The commissioner shall publish a list of all certified reinsurers and their ratings.

(1) Each certified reinsurer shall be rated on a legal entity basis, with due consideration being given to the group rating where appropriate, except that an association including incorporated and individual unincorporated underwriters that has been approved to

do business as a single certified reinsurer may be evaluated on the basis of its group rating. Factors that may be considered as part of the evaluation process include, but are not limited to, the following:

(A) The certified reinsurer's financial strength rating from an acceptable rating agency. The maximum rating that a certified reinsurer may be assigned shall correspond to its financial strength rating as set forth in clauses (i) to (vi), inclusive. The commissioner shall use the lowest financial strength rating received from an approved rating agency in establishing the maximum rating of a certified reinsurer. A failure to obtain or maintain at least two financial strength ratings from acceptable rating agencies shall result in loss of eligibility for certification.

(i) Ratings category "Secure - 1" corresponds to A.M. Best Company rating A++; Standard & Poor's rating AAA; Moody's Investors Service rating Aaa; and Fitch Ratings rating AAA.

(ii) Ratings category "Secure - 2" corresponds to A.M. Best Company rating A+; Standard & Poor's rating AA+, AA, or AA-; Moody's Investors Service rating Aa1, Aa2, or Aa3; and Fitch Ratings rating AA+, AA, or AA-.

(iii) Ratings category "Secure - 3" corresponds to A.M. Best Company rating A; Standard & Poor's rating A+ or A; Moody's Investors Service rating A1 or A2; and Fitch Ratings rating A+ or A.

(iv) Ratings category "Secure - 4" corresponds to A.M. Best Company rating A-; Standard & Poor's rating A-; Moody's Investors Service rating A3; and Fitch Ratings rating A-.

(v) Ratings category "Secure - 5" corresponds to A.M. Best Company rating B++ or B+; Standard & Poor's rating BBB+, BBB, or BBB-; Moody's Investors Service rating Baa1, Baa2, or Baa3; and Fitch Ratings rating BBB+, BBB, or BBB-.

(vi) Ratings category "Vulnerable - 6" corresponds to A.M. Best Company rating B, B-, C++, C+, C, C-, D, E, or F; Standard & Poor's rating BB+, BB, BB-, B+, B, B-, CCC, CC, C, D, or R; Moody's Investors Service rating Ba1, Ba2, Ba3, B1, B2, B3, Caa, Ca, or C; and Fitch Ratings rating BB+, BB, BB-, B+, B, B-, CCC+, CC, CCC-, or DD.

(B) The business practices of the certified reinsurer in dealing with its ceding insurers, including its record of compliance with reinsurance contractual terms and obligations.

(C) For certified reinsurers domiciled in the United States, a review of the most recent applicable NAIC Annual Statement Blank, either Schedule F (for property/casualty reinsurers) or Schedule S (for life and health reinsurers).

(D) For certified reinsurers not domiciled in the United States, a review annually of Form CR-F (for property/casualty reinsurers) or Form CR-S (for life and health reinsurers) (as published on the department's Internet Web site).

(E) The reputation of the certified reinsurer for prompt payment of claims under reinsurance agreements, based on an analysis of ceding insurers' Schedule F reporting of overdue reinsurance recoverables, including the proportion of obligations that are more than 90 days past due or are in dispute, with specific attention given to obligations payable to companies that are in administrative supervision or receivership.

(F) Regulatory actions against the certified reinsurer.

(G) The report of the independent auditor on the financial statements of the insurance enterprise, on the basis described in subparagraph (H).

(H) For certified reinsurers not domiciled in the United States, audited financial statements, (audited United States Generally Accepted Accounting Principles basis, if available, audited International Financial Reporting Standards basis statements are allowed, but must include an audited footnote reconciling equity and net income to a United States Generally Accepted Accounting Principles basis, or, with the written permission of the commissioner, audited International Financial Reporting Standards statements with reconciliation to United States Generally Accepted Accounting Principles certified by an officer of the company), regulatory filings, and actuarial opinion (as filed with the non-United States jurisdiction supervisor). Upon the initial application for certification, the commissioner shall consider audited financial statements for the last three years filed with its non-United States jurisdiction supervisor.

(I) The liquidation priority of obligations to a ceding insurer in the certified reinsurer's domiciliary jurisdiction in the context of an insolvency proceeding.

(J) A certified reinsurer's participation in any solvent scheme of arrangement, or similar procedure, which involves United States ceding insurers. The commissioner shall receive prior notice from

a certified reinsurer that proposes participation by the certified reinsurer in a solvent scheme of arrangement.

(K) Any other information deemed relevant by the commissioner.

(2) Based on the analysis conducted under subparagraph (E) of paragraph (1) of a certified reinsurer's reputation for prompt payment of claims, the commissioner may make appropriate adjustments in the security the certified reinsurer is required to post to protect its liabilities to United States ceding insurers, provided that the commissioner shall, at a minimum, increase the security the certified reinsurer is required to post by one rating level under regulations promulgated by the commissioner, if the commissioner finds either of the following:

(A) More than 15 percent of the certified reinsurer's ceding insurance clients have overdue reinsurance recoverables on paid losses of 90 days or more that are not in dispute and that exceed one hundred thousand dollars ($100,000) for each ceding insurer.

(B) The aggregate amount of reinsurance recoverables on paid losses that are not in dispute and that are overdue by 90 days or more exceeds fifty million dollars ($50,000,000).

(3) The assuming insurer shall submit a properly executed Form CR-1 (as published on the department's Internet Web site) as evidence of its submission to the jurisdiction of this state, appointment of the commissioner as an agent for service of process in this state, and agreement to provide security for 100 percent of the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers if it resists enforcement of a final United States judgment. The commissioner shall not certify any assuming insurer that is domiciled in a jurisdiction that the commissioner has determined does not adequately and promptly enforce final United States judgments or arbitration awards.

(4) (A) In the case of a downgrade by a rating agency or other disqualifying circumstance, the commissioner shall, upon written notice, assign a new rating to the certified reinsurer in accordance with the requirements of this subdivision.

(B) The commissioner shall have the authority to suspend, revoke, or otherwise modify a certified reinsurer's certification at any time if the certified reinsurer fails to meet its obligations or security requirements under this section, or if other financial or operating results of the certified reinsurer, or documented

significant delays in payment by the certified reinsurer, lead the commissioner to reconsider the certified reinsurer's ability or willingness to meet its contractual obligations.

(C) If the rating of a certified reinsurer is upgraded by the commissioner, the certified reinsurer may meet the security requirements applicable to its new rating on a prospective basis, but the commissioner shall require the certified reinsurer to post security under the previously applicable security requirements as to all contracts in force on or before the effective date of the upgraded rating. If the rating of a certified reinsurer is downgraded by the commissioner, the commissioner shall require the certified reinsurer to meet the security requirements applicable to its new rating for all business it has assumed as a certified reinsurer.

(D) Upon revocation of the certification of a certified reinsurer by the commissioner, the assuming insurer shall be required to post security in accordance with Section 922.5 in order for the ceding insurer to continue to take credit for reinsurance ceded to the assuming insurer. If funds continue to be held in trust in accordance with subdivision (d) of Section 922.4, the commissioner may allow additional credit equal to the ceding insurer's pro rata share of those funds, discounted to reflect the risk of uncollectibility and anticipated expenses of trust administration. Notwithstanding the change of a certified reinsurer's rating or revocation of its certification, a domestic insurer that has ceded reinsurance to that certified reinsurer shall not be denied credit for reinsurance for a period of three months for all reinsurance ceded to that certified reinsurer, unless the reinsurance is found by the commissioner to be at high risk of uncollectibility.

(i) A certified reinsurer shall secure obligations assumed from United States ceding insurers under this subdivision at a level consistent with its rating. The amount of security required in order for full credit to be allowed shall correspond with the following requirements:

Ratings security required
Secure - 1: 0 percent
Secure - 2: 10 percent
Secure - 3: 20 percent
Secure - 4: 50 percent
Secure - 5: 75 percent
Vulnerable - 6: 100 percent

(1) In order for a domestic ceding insurer to qualify for full financial statement credit for reinsurance ceded to a certified reinsurer, the certified reinsurer shall maintain security in a form acceptable to the commissioner and consistent with Section 922.5, or in a multibeneficiary trust in accordance with subdivision (d) of Section 922.4, except as otherwise provided in this subdivision. In order for a domestic insurer to qualify for full financial statement credit, reinsurance contracts entered into or renewed under this section shall include a proper funding clause that requires the certified reinsurer to provide and maintain security in an amount sufficient to avoid the imposition of any financial statement penalty on the ceding insurer under this section for reinsurance ceded to the certified reinsurer.

(2) If a certified reinsurer maintains a trust to fully secure its obligations subject to subdivision (d) of Section 922.4, and chooses to secure its obligations incurred as a certified reinsurer in the form of a multibeneficiary trust, the certified reinsurer shall maintain separate trust accounts for its obligations incurred under reinsurance agreements issued or renewed as a certified reinsurer with reduced security as permitted by this subdivision or comparable laws of other United States jurisdictions and for its obligations subject to subdivision (d) of Section 922.4. It shall be a condition to the grant of certification under this section that the certified reinsurer shall have bound itself, by the language of the trust and agreement with the commissioner with principal regulatory oversight of each of those trust accounts, to fund, upon termination of any of those trust accounts, out of the remaining surplus of those trusts any deficiency of any other of those trust accounts.

(3) The minimum trusteed surplus requirements provided in subdivision (d) of Section 922.4 are not applicable with respect to a multibeneficiary trust maintained by a certified reinsurer for the purpose of securing obligations incurred under this subdivision, except that the trust shall maintain a minimum trusteed surplus of ten million dollars ($10,000,000).

(4) With respect to obligations incurred by a certified reinsurer under this subdivision, if the security is insufficient, the commissioner shall reduce the allowable credit by an amount proportionate to the deficiency, and have the discretion to impose further reductions in allowable credit upon finding that there is a

material risk that the certified reinsurer's obligations will not be paid in full when due.

(5) For purposes of this subdivision, a certified reinsurer whose certification has been terminated for any reason shall be treated as a certified reinsurer required to secure 100 percent of its obligations.

(A) As used in this subdivision, the term "terminated" means revocation, suspension, voluntary surrender, and inactive status.

(B) If the commissioner continues to assign a higher rating as permitted by other provisions of this section, this requirement shall not apply to a certified reinsurer in inactive status or to a reinsurer whose certification has been suspended.

(6) The commissioner shall require the certified reinsurer to post 100-percent security in accordance with Section 922.5, for the benefit of the ceding insurer or its estate, upon the entry of an order of rehabilitation, liquidation, or conservation against the ceding insurer.

(7) Affiliated reinsurance transactions shall receive the same opportunity for reduced security requirements as all other reinsurance transactions.

(8) In order to facilitate the prompt payment of claims, a certified reinsurer shall not be required to post security for catastrophe recoverables for a period of one year from the date of the first instance of a liability reserve entry by the ceding company as a result of a loss from a catastrophic occurrence that is likely to result in significant insured losses, as recognized by the commissioner. The one-year deferral period is contingent upon the certified reinsurer continuing to pay claims in a timely manner, as determined by the commissioner, in writing. Reinsurance recoverables for only the following lines of business as reported on the NAIC annual financial statement related specifically to the catastrophic occurrence shall be included in the deferral:

(A) Line 1: Fire.

(B) Line 2: Allied lines.

(C) Line 3: Farmowners' multiple peril.

(D) Line 4: Homeowners' multiple peril.

(E) Line 5: Commercial multiple peril.

(F) Line 9: Inland marine.

(G) Line 12: Earthquake.

(H) Line 21: Auto physical damage.

(9) Credit for reinsurance under this section shall apply only to reinsurance contracts entered into or renewed on or after the effective date of the certification of the assuming insurer. Any reinsurance contract entered into prior to the effective date of the certification of the assuming insurer that is subsequently amended by mutual agreement of the parties to the reinsurance contract after the effective date of the certification of the assuming insurer, or a new reinsurance contract, covering any risk for which collateral was provided previously, shall only be subject to this section with respect to losses incurred and reserves reported from and after the effective date of the amendment or new contract.

(10) Nothing in this section shall be construed to prohibit the parties to a reinsurance agreement from agreeing to provisions establishing security requirements that exceed the minimum security requirements established for certified reinsurers under this section.

(j) A certified reinsurer that ceases to assume new business in this state may request to maintain its certification in inactive status in order to continue to qualify for a reduction in security for its in-force business. An inactive certified reinsurer shall continue to comply with all applicable requirements of this section, and the commissioner shall assign a rating that takes into account, if relevant, the reasons why the reinsurer is not assuming new business.

(k) Notwithstanding this section, credit for reinsurance or deduction from liability by a domestic ceding insurer for cessions to a certified reinsurer may be disallowed upon a finding by the commissioner that the application of the literal provisions of this section does not accomplish its intent, or either the financial condition of the reinsurer or the collateral or other security provided by the reinsurer does not, in substance, satisfy the credit for reinsurance requirements in Section 922.4.

(*l*) This section shall remain in effect only until January 1, 2021, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2021, deletes or extends that date.

SEC. 9. Section 1725.5 of the Insurance Code is amended to read:

1725.5. (a) For purposes of Sections 32.5, 1625, 1626, 1724.5, 1758.1, 1765, 1800, 14020, 14021, and 15006, every licensee shall prominently affix, type, or cause to be printed on business cards,

written price quotations for insurance products, and print advertisements distributed exclusively in this state for insurance products its license number in type the same size as any indicated telephone number, address, or fax number. If the licensee maintains more than one organization license, one of the organization license numbers is sufficient for compliance with this section.

(b) Effective January 1, 2005, for purposes of Sections 32.5, 1625, 1626, 1724.5, 1758.1, 1765, 1800, 14020, 14021, and 15006, every licensee shall prominently affix, type, or cause to be printed on business cards, written price quotations for insurance products, and print advertisements, distributed in this state for insurance products, the word "Insurance" in type size no smaller than the largest indicated telephone number.

(c) In the case of transactors, or agent and broker licensees, who are classified for licensing purposes as solicitors, working as exclusive employees of motor clubs, organizational licensee numbers shall be used.

(d) Any person in violation of this section shall be subject to a fine levied by the commissioner in the amount of two hundred dollars ($200) for the first offense, five hundred dollars ($500) for the second offense, and one thousand dollars ($1,000) for the third and subsequent offenses. The penalty shall not exceed one thousand dollars ($1,000) for any one offense. These fines shall be deposited into the Insurance Fund.

(e) A separate penalty shall not be imposed upon each piece of printed material that fails to conform to the requirements of this section.

(f) If the commissioner finds that the failure of a licensee to comply with the provisions of subdivision (a) or (b) is due to reasonable cause or circumstance beyond the licensee's control, and occurred notwithstanding the exercise of ordinary care and in the absence of willful neglect, the licensee may be relieved of the penalty in subdivision (d).

(g) A licensee seeking to be relieved of the penalty in subdivision (d) shall file with the department a statement with supporting documents setting forth the facts upon which the licensee bases its claims for relief.

(h) This section does not apply to any person or entity that is not currently required to be licensed by the department or that is exempted from licensure.

(i) This section does not apply to general advertisements of motor clubs that merely list insurance products as one of several services offered by the motor club, and do not provide any details of the insurance products.

(j) This section does not apply to life insurance policy illustrations required by Chapter 5.5 (commencing with Section 10509.950) of Part 2 of Division 2 or to life insurance cost indexes required by Chapter 5.6 (commencing with Section 10509.970) of Part 2 of Division 2.

(k) This section shall become operative January 1, 1997.

(*l*) This section shall remain in effect only until July 1, 2016, and as of that date is repealed, unless a later enacted statute, that is enacted before July 1, 2016, deletes or extends that date.

SEC. 10. Section 1725.5 is added to the Insurance Code, to read:

1725.5. (a) For purposes of Sections 32.5, 1625, 1626, 1724.5, 1758.1, 1765, 1800, 14020, 14021, and 15006, every licensee shall prominently affix, type, or cause to be printed on business cards, written price quotations for insurance products, and print advertisements distributed exclusively in this state for insurance products its license number in type the same size as any indicated telephone number, address, or fax number. If the licensee maintains more than one organization license, one of the organization license numbers is sufficient for compliance with this section.

(b) Effective January 1, 2005, for purposes of Sections 32.5, 1625, 1626, 1724.5, 1758.1, 1765, 14020, 14021, and 15006, every licensee shall prominently affix, type, or cause to be printed on business cards, written price quotations for insurance products, and print advertisements, distributed in this state for insurance products, the word “Insurance” in type size that is at least as large as the smallest telephone number or 12-point type, whichever is larger.

(c) In the case of transactors, or agent and broker licensees, who are classified for licensing purposes as solicitors, working as exclusive employees of motor clubs, organizational licensee numbers shall be used.

(d) Any person in violation of this section shall be subject to a fine levied by the commissioner in the amount of two hundred dollars ($200) for the first offense, five hundred dollars ($500) for the second offense, and one thousand dollars ($1,000) for the third

and subsequent offenses. The penalty shall not exceed one thousand dollars ($1,000) for any one offense. These fines shall be deposited into the Insurance Fund.

(e) A separate penalty shall not be imposed upon each piece of printed material that fails to conform to the requirements of this section.

(f) If the commissioner finds that the failure of a licensee to comply with the provisions of subdivision (a) or (b) is due to reasonable cause or circumstance beyond the licensee's control, and occurred notwithstanding the exercise of ordinary care and in the absence of willful neglect, the licensee may be relieved of the penalty in subdivision (d).

(g) A licensee seeking to be relieved of the penalty in subdivision (d) shall file with the department a statement with supporting documents setting forth the facts upon which the licensee bases its claims for relief.

(h) This section does not apply to any person or entity that is not currently required to be licensed by the department or that is exempted from licensure.

(i) This section does not apply to general advertisements of motor clubs that merely list insurance products as one of several services offered by the motor club, and do not provide any details of the insurance products.

(j) This section does not apply to life insurance policy illustrations required by Chapter 5.5 (commencing with Section 10509.950) of Part 2 of Division 2 or to life insurance cost indexes required by Chapter 5.6 (commencing with Section 10509.970) of Part 2 of Division 2.

(k) This section shall become operative July 1, 2016.

SEC. 11. Section 1729.2 of the Insurance Code is amended to read:

1729.2. (a) An applicant or licensee shall notify the commissioner when any of the background information set forth in this section changes after the application has been submitted or the license has been issued. If the licensee is listed as an endorsee on any business entity license, the licensee shall also provide this notice to any officer, director, or partner listed on that business entity license.

(b) A business entity licensee, upon learning of a change in background information pertaining to any unlicensed person listed

on its business entity license or application therefor, shall notify the commissioner of that change. The changes subject to this requirement include changes pertaining to any unlicensed officer, director, partner, member, or controlling person, or any other natural person named under the business entity license or in an application therefor.

(c) The following definitions apply for the purposes of this section:

(1) "License" includes all types of licenses issued by the commissioner pursuant to Chapter 5 (commencing with Section 1621), Chapter 5A (commencing with Section 1759), Chapter 6 (commencing with Section 1760), Chapter 6.5 (commencing with Section 1781.1), Chapter 7 (commencing with Section 1800), and Chapter 8 (commencing with Section 1831) of Part 2 of Division 1, Chapter 1 (commencing with Section 10110) of Part 2 of Division 2, Chapter 4 (commencing with Section 12280) of Part 5 of Division 2, Article 8 (commencing with Section 12418) of Chapter 1 of Part 6 of Division 2, and Chapter 1 (commencing with Section 14000) and Chapter 2 (commencing with Section 15000) of Division 5.

(2) "Background information" means any of the following: a misdemeanor or felony conviction; a filing of felony criminal charges in state or federal court; an administrative action regarding a professional or occupational license; any licensee's discharge or attempt to discharge, in a personal or organizational bankruptcy proceeding, an obligation regarding any insurance premiums or fiduciary funds owed to any company, including a premium finance company, or managing general agent; and any admission, or judicial finding or determination, of fraud, misappropriation or conversion of funds, misrepresentation, or breach of fiduciary duty.

(3) "Applicant" and "licensee" include individual and organization applicants and licensees, and officers, directors, partners, members, and controlling persons (as defined in subdivision (b) of Section 1668.5) of an organization.

(d) Notification to the commissioner shall be in writing and shall be sent within 30 days of the date the applicant or licensee learns of the change in background information.

(e) The commissioner may adopt regulations necessary or desirable to implement this section.

SEC. 12. Section 1764.1 of the Insurance Code is amended to read:

1764.1. (a) (1) Every nonadmitted insurer, in the case of insurance to be purchased by a home state insured pursuant to Section 1760, and surplus line broker, in the case of any insurance with a nonadmitted carrier for a home state insured to be transacted by the surplus line broker, shall be responsible to ensure that, at the time of accepting an application for an insurance policy, other than a renewal of that policy, issued by a nonadmitted insurer, the signature of the applicant on the disclosure statement set forth in subdivision (b) is obtained. In fulfillment of this responsibility, the nonadmitted insurer and the surplus line broker may rely, if it is reasonable under all the circumstances to do so, on the disclosure statement received from a licensee involved in the transaction as prima facie evidence that the disclosure statement and appropriate signature from the applicant have been obtained. The surplus line broker shall maintain a copy of the signed disclosure statement in his or her records for a period of at least five years. These records shall be made available to the commissioner and the insured upon request. This disclosure shall be signed by the applicant, and is not subject to a limited power of attorney agreement between the applicant and an agent or broker or a surplus line broker. The disclosure statement shall be in boldface 16-point type on a freestanding document. In addition, every policy issued by a nonadmitted insurer and every certificate evidencing the placement of insurance shall contain, or have affixed to it by the insurer or surplus line broker, the disclosure statement set forth in subdivision (b) in boldface 16-point type on the front page of the policy.

(2) In a case in which the applicant has not received and completed the signed disclosure form required by this section, he or she may cancel the insurance so placed. The cancellation shall be on a pro rata basis as to premium, and the applicant shall be entitled to the return of any broker's fees charged for the placement.

(b) The following notice shall be provided to home state insureds and home state insured applicants for insurance as provided by subdivision (a), and shall be printed in English and in the language principally used by the surplus line broker and nonadmitted insurer to advertise, solicit, or negotiate the sale and purchase of surplus line insurance. The surplus line broker and nonadmitted insurer

shall use the appropriate bracketed language for application and issued policy disclosures:

"NOTICE:

1. THE INSURANCE POLICY THAT YOU [HAVE PURCHASED] [ARE APPLYING TO PURCHASE] IS BEING ISSUED BY AN INSURER THAT IS NOT LICENSED BY THE STATE OF CALIFORNIA. THESE COMPANIES ARE CALLED "NONADMITTED" OR "SURPLUS LINE" INSURERS.

2. THE INSURER IS NOT SUBJECT TO THE FINANCIAL SOLVENCY REGULATION AND ENFORCEMENT THAT APPLY TO CALIFORNIA LICENSED INSURERS.

3. THE INSURER DOES NOT PARTICIPATE IN ANY OF THE INSURANCE GUARANTEE FUNDS CREATED BY CALIFORNIA LAW. THEREFORE, THESE FUNDS WILL NOT PAY YOUR CLAIMS OR PROTECT YOUR ASSETS IF THE INSURER BECOMES INSOLVENT AND IS UNABLE TO MAKE PAYMENTS AS PROMISED.

4. THE INSURER SHOULD BE LICENSED EITHER AS A FOREIGN INSURER IN ANOTHER STATE IN THE UNITED STATES OR AS A NON-UNITED STATES (ALIEN) INSURER. YOU SHOULD ASK QUESTIONS OF YOUR INSURANCE AGENT, BROKER, OR "SURPLUS LINE" BROKER OR CONTACT THE CALIFORNIA DEPARTMENT OF INSURANCE AT THE FOLLOWING TOLL-FREE TELEPHONE NUMBER ____. ASK WHETHER OR NOT THE INSURER IS LICENSED AS A FOREIGN OR NON-UNITED STATES (ALIEN) INSURER AND FOR ADDITIONAL INFORMATION ABOUT THE INSURER. YOU MAY ALSO CONTACT THE NAIC'S INTERNET WEB SITE AT WWW.NAIC.ORG.

5. FOREIGN INSURERS SHOULD BE LICENSED BY A STATE IN THE UNITED STATES AND YOU MAY CONTACT THAT STATE'S DEPARTMENT OF INSURANCE TO OBTAIN MORE INFORMATION ABOUT THAT INSURER.

6. FOR NON-UNITED STATES (ALIEN) INSURERS, THE INSURER SHOULD BE LICENSED BY A COUNTRY OUTSIDE OF THE UNITED STATES AND SHOULD BE ON THE NAIC'S INTERNATIONAL INSURERS DEPARTMENT

(IID) LISTING OF APPROVED NONADMITTED NON-UNITED STATES INSURERS. ASK YOUR AGENT, BROKER, OR "SURPLUS LINE" BROKER TO OBTAIN MORE INFORMATION ABOUT THAT INSURER.

7. CALIFORNIA MAINTAINS A LIST OF APPROVED SURPLUS LINE INSURERS. ASK YOUR AGENT OR BROKER IF THE INSURER IS ON THAT LIST, OR VIEW THAT LIST AT THE INTERNET WEB SITE OF THE CALIFORNIA DEPARTMENT OF INSURANCE: WWW.INSURANCE.CA.GOV.

8. IF YOU, AS THE APPLICANT, REQUIRED THAT THE INSURANCE POLICY YOU HAVE PURCHASED BE BOUND IMMEDIATELY, EITHER BECAUSE EXISTING COVERAGE WAS GOING TO LAPSE WITHIN TWO BUSINESS DAYS OR BECAUSE YOU WERE REQUIRED TO HAVE COVERAGE WITHIN TWO BUSINESS DAYS, AND YOU DID NOT RECEIVE THIS DISCLOSURE FORM AND A REQUEST FOR YOUR SIGNATURE UNTIL AFTER COVERAGE BECAME EFFECTIVE, YOU HAVE THE RIGHT TO CANCEL THIS POLICY WITHIN FIVE DAYS OF RECEIVING THIS DISCLOSURE. IF YOU CANCEL COVERAGE, THE PREMIUM WILL BE PRORATED AND ANY BROKER'S FEE CHARGED FOR THIS INSURANCE WILL BE RETURNED TO YOU."

(c) When a contract is issued to an industrial insured, neither the nonadmitted insurer nor the surplus line broker is required to provide the notice required in this section except on the confirmation of insurance, the certificate of placement, or the policy, whichever is first provided to the insured, nor is the insurer or surplus line broker required to obtain the insured's signature. The producer shall ensure that the notice affixed to the confirmation of insurance, certificate of placement, or the policy is provided to the insured. The producer shall insert the current toll-free telephone number of the Department of Insurance as provided in paragraph 4 of the notice.

(1) An industrial insured is an insured that does both of the following:

(A) Employs at least 25 employees on average during the prior 12 months.

(B) Has aggregate annual premiums for insurance for all risks other than workers' compensation and health coverage totaling no less than twenty-five thousand dollars ($25,000) or obtains insurance through the services of a full-time employee acting as an insurance manager or a continuously retained insurance consultant. A "continuously retained insurance consultant" does not include: (i) an agent or broker through whom the insurance is being placed, (ii) a subagent or subproducer involved in the transaction, or (iii) an agent or broker that is a business organization employing or contracting with a person mentioned in clauses (i) and (ii).

(2) The surplus line broker shall be responsible for ensuring that the applicant is an industrial insured. A surplus line broker who reasonably relies on information provided in good faith by the applicant, whether directly or through the producer, shall be deemed to be in compliance with this requirement.

(d) For purposes of compliance with the requirement of subdivision (a) that the signature of the applicant be obtained, the following shall apply:

(1) If the insurance transaction is not conducted at an in-person, face-to-face meeting, the applicant's signature on the disclosure form may be transmitted by the applicant to the agent or broker via facsimile or comparable electronic transmittal.

(2) In the case of commercial lines coverage, or personal insurance coverage subject to Section 675 and any umbrella coverage associated therewith, where an applicant requires that insurance coverage be bound immediately, either because existing coverage will lapse within two business days of the time the insurance is bound or because the applicant is required to have coverage in place within two business days, and the applicant cannot meet in person with the agent or broker to sign the disclosure form, the agent or broker may obtain the signature of the applicant within five days of binding coverage, provided that the applicant may cancel the insurance so placed within five days of receiving the disclosure form from the agent or broker. The cancellation shall be on a pro rata basis, and the applicant shall be entitled to the rescission or return of any broker's fees charged for the placement. When a policy is canceled, the broker shall inform the applicant that the broker's fee must be returned and that the premium must be prorated.

(e) Notwithstanding subdivision (a), this section shall not apply to insurance issued or delivered in this state by a nonadmitted Mexican insurer by and through a surplus line broker affording coverage exclusively in the Republic of Mexico on property located temporarily or permanently in, or operations conducted temporarily or permanently within, the Republic of Mexico.

(f) This section shall remain in effect only until January 1, 2017, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2017, deletes or extends that date.

SEC. 13. Section 1764.1 is added to the Insurance Code, to read:

1764.1. (a) (1) Every nonadmitted insurer, in the case of insurance to be purchased by a home state insured pursuant to Section 1760, and surplus line broker, in the case of any insurance with a nonadmitted carrier for a home state insured to be transacted by the surplus line broker, shall be responsible to ensure that, at the time of accepting an application for an insurance policy, other than a renewal of that policy, issued by a nonadmitted insurer, the signature of the applicant on the disclosure statement set forth in subdivision (b) is obtained. In fulfillment of this responsibility, the nonadmitted insurer and the surplus line broker may rely, if it is reasonable under all the circumstances to do so, on the disclosure statement received from a licensee involved in the transaction as prima facie evidence that the disclosure statement and appropriate signature from the applicant have been obtained. The surplus line broker shall maintain a copy of the signed disclosure statement in his or her records for a period of at least five years. These records shall be made available to the commissioner and the insured upon request. This disclosure shall be signed by the applicant, and is not subject to a limited power of attorney agreement between the applicant and an agent or broker or a surplus line broker. The disclosure statement shall be in boldface 16-point type on a freestanding document. In addition, every policy issued by a nonadmitted insurer and every certificate evidencing the placement of insurance shall contain, or have affixed to it by the insurer or surplus line broker, the disclosure statement set forth in subdivision (b) in boldface 16-point type on the front page of the policy.

(2) In a case in which the applicant has not received and completed the signed disclosure form required by this section, he or she may cancel the insurance so placed. The cancellation shall

be on a pro rata basis as to premium, and the applicant shall be entitled to the return of any broker's fees charged for the placement.

(b) The following notice shall be provided to home state insureds and home state insured applicants for insurance as provided by subdivision (a), and shall be printed in English and in the language principally used by the surplus line broker and nonadmitted insurer to advertise, solicit, or negotiate the sale and purchase of surplus line insurance. The surplus line broker and nonadmitted insurer shall use the appropriate bracketed language for application and issued policy disclosures:

"NOTICE:

1. THE INSURANCE POLICY THAT YOU [HAVE PURCHASED] [ARE APPLYING TO PURCHASE] IS BEING ISSUED BY AN INSURER THAT IS NOT LICENSED BY THE STATE OF CALIFORNIA. THESE COMPANIES ARE CALLED "NONADMITTED" OR "SURPLUS LINE" INSURERS.

2. THE INSURER IS NOT SUBJECT TO THE FINANCIAL SOLVENCY REGULATION AND ENFORCEMENT THAT APPLY TO CALIFORNIA LICENSED INSURERS.

3. THE INSURER DOES NOT PARTICIPATE IN ANY OF THE INSURANCE GUARANTEE FUNDS CREATED BY CALIFORNIA LAW. THEREFORE, THESE FUNDS WILL NOT PAY YOUR CLAIMS OR PROTECT YOUR ASSETS IF THE INSURER BECOMES INSOLVENT AND IS UNABLE TO MAKE PAYMENTS AS PROMISED.

4. THE INSURER SHOULD BE LICENSED EITHER AS A FOREIGN INSURER IN ANOTHER STATE IN THE UNITED STATES OR AS A NON-UNITED STATES (ALIEN) INSURER. YOU SHOULD ASK QUESTIONS OF YOUR INSURANCE AGENT, BROKER, OR "SURPLUS LINE" BROKER OR CONTACT THE CALIFORNIA DEPARTMENT OF INSURANCE AT THE FOLLOWING TOLL-FREE TELEPHONE NUMBER ____ OR INTERNET WEB SITE WWW.INSURANCE.CA.GOV. ASK WHETHER OR NOT THE INSURER IS LICENSED AS A FOREIGN OR NON-UNITED STATES (ALIEN) INSURER AND FOR ADDITIONAL INFORMATION ABOUT THE INSURER. YOU MAY ALSO

CONTACT THE NAIC'S INTERNET WEB SITE AT WWW.NAIC.ORG.

5. FOREIGN INSURERS SHOULD BE LICENSED BY A STATE IN THE UNITED STATES AND YOU MAY CONTACT THAT STATE'S DEPARTMENT OF INSURANCE TO OBTAIN MORE INFORMATION ABOUT THAT INSURER.

6. FOR NON-UNITED STATES (ALIEN) INSURERS, THE INSURER SHOULD BE LICENSED BY A COUNTRY OUTSIDE OF THE UNITED STATES AND SHOULD BE ON THE NAIC'S INTERNATIONAL INSURERS DEPARTMENT (IID) LISTING OF APPROVED NONADMITTED NON-UNITED STATES INSURERS. ASK YOUR AGENT, BROKER, OR "SURPLUS LINE" BROKER TO OBTAIN MORE INFORMATION ABOUT THAT INSURER.

7. CALIFORNIA MAINTAINS A LIST OF APPROVED SURPLUS LINE INSURERS. ASK YOUR AGENT OR BROKER IF THE INSURER IS ON THAT LIST, OR VIEW THAT LIST AT THE INTERNET WEB SITE OF THE CALIFORNIA DEPARTMENT OF INSURANCE: WWW.INSURANCE.CA.GOV.

8. IF YOU, AS THE APPLICANT, REQUIRED THAT THE INSURANCE POLICY YOU HAVE PURCHASED BE BOUND IMMEDIATELY, EITHER BECAUSE EXISTING COVERAGE WAS GOING TO LAPSE WITHIN TWO BUSINESS DAYS OR BECAUSE YOU WERE REQUIRED TO HAVE COVERAGE WITHIN TWO BUSINESS DAYS, AND YOU DID NOT RECEIVE THIS DISCLOSURE FORM AND A REQUEST FOR YOUR SIGNATURE UNTIL AFTER COVERAGE BECAME EFFECTIVE, YOU HAVE THE RIGHT TO CANCEL THIS POLICY WITHIN FIVE DAYS OF RECEIVING THIS DISCLOSURE. IF YOU CANCEL COVERAGE, THE PREMIUM WILL BE PRORATED AND ANY BROKER'S FEE CHARGED FOR THIS INSURANCE WILL BE RETURNED TO YOU."

(c) When a contract is issued to an industrial insured, neither the nonadmitted insurer nor the surplus line broker is required to provide the notice required in this section except on the confirmation of insurance, the certificate of placement, or the policy, whichever is first provided to the insured, nor is the insurer or surplus line broker required to obtain the insured's signature.

The producer shall ensure that the notice affixed to the confirmation of insurance, certificate of placement, or the policy is provided to the insured. The producer shall insert the current toll-free telephone number of the Department of Insurance as provided in paragraph 4 of the notice.

(1) An industrial insured is an insured that does both of the following:

(A) Employs at least 25 employees on average during the prior 12 months.

(B) Has aggregate annual premiums for insurance for all risks other than workers' compensation and health coverage totaling no less than twenty-five thousand dollars ($25,000) or obtains insurance through the services of a full-time employee acting as an insurance manager or a continuously retained insurance consultant. A "continuously retained insurance consultant" does not include: (i) an agent or broker through whom the insurance is being placed, (ii) a subagent or subproducer involved in the transaction, or (iii) an agent or broker that is a business organization employing or contracting with a person mentioned in clauses (i) and (ii).

(2) The surplus line broker shall be responsible for ensuring that the applicant is an industrial insured. A surplus line broker who reasonably relies on information provided in good faith by the applicant, whether directly or through the producer, shall be deemed to be in compliance with this requirement.

(d) For purposes of compliance with the requirement of subdivision (a) that the signature of the applicant be obtained, the following shall apply:

(1) If the insurance transaction is not conducted at an in-person, face-to-face meeting, the applicant's signature on the disclosure form may be transmitted by the applicant to the agent or broker via facsimile or comparable electronic transmittal.

(2) In the case of commercial lines coverage, or personal insurance coverage subject to Section 675 and any umbrella coverage associated therewith, where an applicant requires that insurance coverage be bound immediately, either because existing coverage will lapse within two business days of the time the insurance is bound or because the applicant is required to have coverage in place within two business days, and the applicant cannot meet in person with the agent or broker to sign the

disclosure form, the agent or broker may obtain the signature of the applicant within five days of binding coverage, provided that the applicant may cancel the insurance so placed within five days of receiving the disclosure form from the agent or broker. The cancellation shall be on a pro rata basis, and the applicant shall be entitled to the rescission or return of any broker's fees charged for the placement. When a policy is canceled, the broker shall inform the applicant that the broker's fee must be returned and that the premium must be prorated.

(e) Notwithstanding subdivision (a), this section shall not apply to insurance issued or delivered in this state by a nonadmitted Mexican insurer by and through a surplus line broker affording coverage exclusively in the Republic of Mexico on property located temporarily or permanently in, or operations conducted temporarily or permanently within, the Republic of Mexico.

(f) This section shall become operative on January 1, 2017.

SEC. 14. Section 1861.02 of the Insurance Code is amended to read:

1861.02. (a) Rates and premiums for an automobile insurance policy, as described in subdivision (a) of Section 660, shall be determined by application of the following factors in decreasing order of importance:

(1) The insured's driving safety record.

(2) The number of miles he or she drives annually.

(3) The number of years of driving experience the insured has had.

(4) Those other factors that the commissioner may adopt by regulation and that have a substantial relationship to the risk of loss. The regulations shall set forth the respective weight to be given each factor in determining automobile rates and premiums. Notwithstanding any other provision of law, the use of any criterion without approval shall constitute unfair discrimination.

(b) (1) Every person who meets the criteria of Section 1861.025 shall be qualified to purchase a Good Driver Discount policy from the insurer of his or her choice. An insurer shall not refuse to offer and sell a Good Driver Discount policy to any person who meets the standards of this subdivision.

(2) The rate charged for a Good Driver Discount policy shall comply with subdivision (a) and shall be at least 20 percent below the rate the insured would otherwise have been charged for the

same coverage. Rates for Good Driver Discount policies shall be approved pursuant to this article.

(3) (A) This subdivision shall not prevent a reciprocal insurer, organized prior to November 8, 1988, by a motor club holding a certificate of authority under Chapter 2 (commencing with Section 12160) of Part 5 of Division 2, and that requires membership in the motor club as a condition precedent to applying for insurance from requiring membership in the motor club as a condition precedent to obtaining insurance described in this subdivision.

(B) This subdivision shall not prevent an insurer that requires membership in a specified voluntary, nonprofit organization, which was in existence prior to November 8, 1988, as a condition precedent to applying for insurance issued to or through those membership groups, including franchise groups, from requiring that membership as a condition to applying for the coverage offered to members of the group, provided that it or an affiliate also offers and sells coverage to those who are not members of those membership groups.

(C) However, all of the following conditions shall be applicable to the insurance authorized by subparagraphs (A) and (B):

(i) Membership, if conditioned, is conditioned only on timely payment of membership dues and other bona fide criteria not based upon driving record or insurance, provided that membership in a motor club may not be based on residence in any area within the state.

(ii) Membership dues are paid solely for and in consideration of the membership and membership benefits and bear a reasonable relationship to the benefits provided. The amount of the dues shall not depend on whether the member purchases insurance offered by the membership organization. None of those membership dues or any portion thereof shall be transferred by the membership organization to the insurer, or any affiliate of the insurer, attorney-in-fact, subsidiary, or holding company thereof, provided that this provision shall not prevent any bona fide transaction between the membership organization and those entities.

(iii) Membership provides bona fide services or benefits in addition to the right to apply for insurance. Those services shall be reasonably available to all members within each class of membership.

Any insurer that violates clause (i), (ii), or (iii) shall be subject to the penalties set forth in Section 1861.14.

(c) The absence of prior automobile insurance coverage, in and of itself, shall not be a criterion for determining eligibility for a Good Driver Discount policy, or generally for automobile rates, premiums, or insurability.

(d) An insurer may refuse to sell a Good Driver Discount policy insuring a motorcycle unless all named insureds have been licensed to drive a motorcycle for the previous three years.

(e) This section shall become operative on November 8, 1989. The commissioner shall adopt regulations implementing this section and insurers may submit applications pursuant to this article which comply with those regulations prior to that date, provided that no such application shall be approved prior to that date.

SEC. 15. Section 1861.025 of the Insurance Code is amended to read:

1861.025. A person is qualified to purchase a Good Driver Discount policy if he or she meets all of the following criteria:

(a) He or she has been licensed to drive a motor vehicle for the previous three years.

(b) During the previous three years, he or she has not done any of the following:

(1) Had more than one violation point count determined as provided by subdivision (a), (b), (c), (d), (f), or (j) of, or paragraph (1) of subdivision (i) of, Section 12810 of the Vehicle Code, but subject to the following modifications:

(A) For the purposes of this section, the driver of a motor vehicle involved in an accident for which he or she was principally at fault that resulted only in damage to property shall receive one violation point count, in addition to any other violation points that may be imposed for this accident.

(B) If, under Section 488 or 488.5, an insurer is prohibited from increasing the premium on a policy on account of a violation, that violation shall not be included in determining the point count of the person.

(C) If a violation is required to be reported under Section 1816 of the Vehicle Code, or under Section 784 of the Welfare and Institutions Code, or any other provision requiring the reporting of a violation by a minor, the violation shall be included for the

purposes of this section in determining the point count in the same manner as is applicable to adult violations.

(2) Had more than one dismissal pursuant to Section 1803.5 of the Vehicle Code that was not made confidential pursuant to Section 1808.7 of the Vehicle Code, in the 36-month period for violations that would have resulted in the imposition of more than one violation point count under paragraph (1) if the complaint had not been dismissed.

(3) Was the driver of a motor vehicle involved in an accident that resulted in bodily injury or in the death of any person and was principally at fault. The commissioner shall adopt regulations setting guidelines to be used by insurers for the determination of fault for the purposes of this paragraph and paragraph (1).

(c) During the period commencing on January 1, 1999, or the date 10 years prior to the date of application for the issuance or renewal of the Good Driver Discount policy, whichever is later, and ending on the date of the application for the issuance or renewal of the Good Driver Discount policy, he or she has not been convicted of a violation of Section 23140, 23152, or 23153 of the Vehicle Code, a felony violation of Section 23550 or 23566, or former Section 23175 or, as those sections read on January 1, 1999, of the Vehicle Code, or a violation of Section 191.5 or subdivision (a) of Section 192.5 of the Penal Code.

(d) Any person who claims that he or she meets the criteria of subdivisions (a), (b), and (c) based entirely or partially on a driver's license and driving experience acquired anywhere other than in the United States or Canada is rebuttably presumed to be qualified to purchase a Good Driver Discount policy if he or she has been licensed to drive in the United States or Canada for at least the previous 18 months and meets the criteria of subdivisions (a), (b), and (c) for that period.

SEC. 16. Section 10111.2 of the Insurance Code is amended to read:

10111.2. (a) Under a policy of disability insurance other than health insurance, as defined in Section 106, including a policy of disability income insurance, as defined in subdivision (i) of Section 799.01, payment of benefits to the insured shall be made within 30 calendar days after the insurer has received all information needed to determine liability for a claim. However, the

30-calendar-day period shall not include any time during which the insurer is doing any of the following:

(1) Awaiting a response for relevant medical information from a health care provider.

(2) Awaiting a response from the claimant to a request for additional relevant information.

(3) Investigating possible fraud that has been reported to the department's Fraud Division in compliance with subdivision (a) of Section 1872.4.

(b) If the insurer has not received all information needed to determine liability for a claim within 30 calendar days after receipt of the claim, the insurer shall notify the insured in writing and include a written list of all information it reasonably needs to determine liability for the claim. In that event, the 30-calendar-day period set out in subdivision (a) shall commence when the insured has provided to the insurer all information in that notification. If no notice is sent by the insurer within 30 calendar days after the claim is filed by the insured, interest shall begin to accrue on the payment of benefits on the 31st calendar day after receipt of the claim, at the rate of 10 percent per year.

(c) When the insurer has received all information needed to determine liability for a claim, and the insurer determines that liability exists and fails to make payment of benefits to the insured within 30 calendar days after the insurer has received that information, any delayed payment shall bear interest, beginning the 31st calendar day, at the rate of 10 percent per year. Liability shall, in all cases, be determined by the insurer within 30 calendar days of receiving all information set out in the insurer's written notification to the insured.

(d) Nothing in this section is intended to restrict any other remedies available to an insured by statute or any other law.

SEC. 17. Section 10127.13 of the Insurance Code, as added by Section 8 of Chapter 166 of the Statutes of 2014, is amended to read:

10127.13. (a) All individual life insurance policies and individual annuity contracts for senior citizens that contain a charge upon surrender, partial surrender, excess withdrawal, or penalties upon surrender shall contain a notice disclosing the location of all of the following: the charge, the charge time period, the charge information, and any associated penalty information. The notice

shall be in bold 12-point type on the front of the policy jacket or on the cover page of the policy.

(b) A policy shall have just one cover page. If the notice required by this section and the statutorily required right to examine notice are both on the cover page, as opposed to the front cover of the policy jacket, they shall appear on the same page.

(c) General references to "policy" in this section refer to both life insurance policies and annuity contracts.

(d) This section shall become operative on July 1, 2015.

SEC. 18. Section 10169 of the Insurance Code, as added by Section 8 of Chapter 872 of the Statutes of 2012, is amended to read:

10169. (a) Commencing January 1, 2001, there is hereby established in the department the Independent Medical Review System.

(b) For the purposes of this chapter, "disputed health care service" means any health care service eligible for coverage and payment under a disability insurance contract that has been denied, modified, or delayed by a decision of the insurer, or by one of its contracting providers, in whole or in part due to a finding that the service is not medically necessary. A decision regarding a disputed health care service relates to the practice of medicine and is not a coverage decision. A disputed health care service does not include services provided by a group or individual policy of vision-only or dental-only coverage, except to the extent that (1) the service involves the practice of medicine, or (2) is provided pursuant to a contract with a disability insurer that covers hospital, medical, or surgical benefits. If an insurer, or one of its contracting providers, issues a decision denying, modifying, or delaying health care services, based in whole or in part on a finding that the proposed health care services are not a covered benefit under the contract that applies to the insured, the statement of decision shall clearly specify the provision in the contract that excludes that coverage.

(c) For the purposes of this chapter, "coverage decision" means the approval or denial of health care services by a disability insurer, or by one of its contracting entities, substantially based on a finding that the provision of a particular service is included or excluded as a covered benefit under the terms and conditions of the disability insurance contract. A coverage decision does not encompass a

disability insurer or contracting provider decision regarding a disputed health care service.

(d) (1) All insured grievances involving a disputed health care service are eligible for review under the Independent Medical Review System if the requirements of this article are met. If the department finds that an insured grievance involving a disputed health care service does not meet the requirements of this article for review under the Independent Medical Review System, the insured request for review shall be treated as a request for the department to review the grievance. All other insured grievances, including grievances involving coverage decisions, remain eligible for review by the department.

(2) In any case in which an insured or provider asserts that a decision to deny, modify, or delay health care services was based, in whole or in part, on consideration of medical necessity, the department shall have the final authority to determine whether the grievance is more properly resolved pursuant to an independent medical review as provided under this article.

(3) The department shall be the final arbiter when there is a question as to whether an insured grievance is a disputed health care service or a coverage decision. The department shall establish a process to complete an initial screening of an insured grievance. If there appears to be any medical necessity issue, the grievance shall be resolved pursuant to an independent medical review as provided under this article.

(e) Every disability insurance contract that is issued, amended, renewed, or delivered in this state on or after January 1, 2000, shall provide an insured with the opportunity to seek an independent medical review whenever health care services have been denied, modified, or delayed by the insurer, or by one of its contracting providers, if the decision was based in whole or in part on a finding that the proposed health care services are not medically necessary. For purposes of this article, an insured may designate an agent to act on his or her behalf. The provider may join with or otherwise assist the insured in seeking an independent medical review, and may advocate on behalf of the insured.

(f) Medicare beneficiaries enrolled in Medicare + Choice products shall not be excluded unless expressly preempted by federal law.

(g) The department may seek to integrate the quality of care and consumer protection provisions, including remedies, of the Independent Medical Review System with related dispute resolution procedures of other health care agency programs, including the Medicare program, in a way that minimizes the potential for duplication, conflict, and added costs. Nothing in this subdivision shall be construed to limit any rights conferred upon insureds under this chapter.

(h) The independent medical review process authorized by this article is in addition to any other procedures or remedies that may be available.

(i) Every disability insurer shall prominently display in every insurer member handbook or relevant informational brochure, in every insurance contract, on insured evidence of coverage forms, on copies of insurer procedures for resolving grievances, on letters of denials issued by either the insurer or its contracting organization, and on all written responses to grievances, information concerning the right of an insured to request an independent medical review when the insured believes that health care services have been improperly denied, modified, or delayed by the insurer, or by one of its contracting providers.

(j) An insured may apply to the department for an independent medical review when all of the following conditions are met:

(1) (A) The insured's provider has recommended a health care service as medically necessary, or

(B) The insured has received urgent care or emergency services that a provider determined was medically necessary, or

(C) The insured, in the absence of a provider recommendation under subparagraph (A) or the receipt of urgent care or emergency services by a provider under subparagraph (B), has been seen by a contracting provider for the diagnosis or treatment of the medical condition for which the insured seeks independent review. The insurer shall expedite access to a contracting provider upon request of an insured. The contracting provider need not recommend the disputed health care service as a condition for the insured to be eligible for an independent review.

For purposes of this article, the insured's provider may be a noncontracting provider. However, the insurer shall have no liability for payment of services provided by a noncontracting provider, except as provided pursuant to Section 10169.3.

(2) The disputed health care service has been denied, modified, or delayed by the insurer, or by one of its contracting providers, based in whole or in part on a decision that the health care service is not medically necessary.

(3) The insured has filed a grievance with the insurer or its contracting provider, and the disputed decision is upheld or the grievance remains unresolved after 30 days. The insured shall not be required to participate in the insurer's grievance process for more than 30 days. In the case of a grievance that requires expedited review, the insured shall not be required to participate in the insurer's grievance process for more than three days.

(k) An insured may apply to the department for an independent medical review of a decision to deny, modify, or delay health care services, based in whole or in part on a finding that the disputed health care services are not medically necessary, within six months of any of the qualifying periods or events under subdivision (j). The commissioner may extend the application deadline beyond six months if the circumstances of a case warrant the extension.

(*l*) The insured shall pay no application or processing fees of any kind.

(m) As part of its notification to the insured regarding a disposition of the insured's grievance that denies, modifies, or delays health care services, the insurer shall provide the insured with a one- or two-page application form approved by the department, and an addressed envelope, which the insured may return to initiate an independent medical review. The insurer shall include on the form any information required by the department to facilitate the completion of the independent medical review, such as the insured's diagnosis or condition, the nature of the disputed health care service sought by the insured, a means to identify the insured's case, and any other material information. The form shall also include the following:

(1) Notice that a decision not to participate in the independent review process may cause the insured to forfeit any statutory right to pursue legal action against the insurer regarding the disputed health care service.

(2) A statement indicating the insured's consent to obtain any necessary medical records from the insurer, any of its contracting providers, and any noncontracting provider the insured may have consulted on the matter, to be signed by the insured.

(3) Notice of the insured's right to provide information or documentation, either directly or through the insured's provider, regarding any of the following:

(A) A provider recommendation indicating that the disputed health care service is medically necessary for the insured's medical condition.

(B) Medical information or justification that a disputed health care service, on an urgent care or emergency basis, was medically necessary for the insured's medical condition.

(C) Reasonable information supporting the insured's position that the disputed health care service is or was medically necessary for the insured's medical condition, including all information provided to the insured by the insurer or any of its contracting providers, still in the possession of the insured, concerning an insurer or provider decision regarding disputed health care services, and a copy of any materials the insured submitted to the insurer, still in the possession of the insured, in support of the grievance, as well as any additional material that the insured believes is relevant.

(4) A section designed to collect information on the insured's ethnicity, race, and primary language spoken that includes both of the following:

(A) A statement of intent indicating that the information is used for statistics only, in order to ensure that all insureds get the best care possible.

(B) A statement indicating that providing this information is optional and will not affect the independent medical review process in any way.

(n) Upon notice from the department that the insured has applied for an independent medical review, the insurer or its contracting providers, shall provide to the independent medical review organization designated by the department a copy of all of the following documents within three business days of the insurer's receipt of the department's notice of a request by an insured for an independent review:

(1) (A) A copy of all of the insured's medical records in the possession of the insurer or its contracting providers relevant to each of the following:

(i) The insured's medical condition.

(ii) The health care services being provided by the insurer and its contracting providers for the condition.

(iii) The disputed health care services requested by the insured for the condition.

(B) Any newly developed or discovered relevant medical records in the possession of the insurer or its contracting providers after the initial documents are provided to the independent medical review organization shall be forwarded immediately to the independent medical review organization. The insurer shall concurrently provide a copy of medical records required by this subparagraph to the insured or the insured's provider, if authorized by the insured, unless the offer of medical records is declined or otherwise prohibited by law. The confidentiality of all medical record information shall be maintained pursuant to applicable state and federal laws.

(2) A copy of all information provided to the insured by the insurer and any of its contracting providers concerning insurer and provider decisions regarding the insured's condition and care, and a copy of any materials the insured or the insured's provider submitted to the insurer and to the insurer's contracting providers in support of the insured's request for disputed health care services. This documentation shall include the written response to the insured's grievance. The confidentiality of any insured medical information shall be maintained pursuant to applicable state and federal laws.

(3) A copy of any other relevant documents or information used by the insurer or its contracting providers in determining whether disputed health care services should have been provided, and any statements by the insurer and its contracting providers explaining the reasons for the decision to deny, modify, or delay disputed health care services on the basis of medical necessity. The insurer shall concurrently provide a copy of documents required by this paragraph, except for any information found by the commissioner to be legally privileged information, to the insured and the insured's provider. The department and the independent medical review organization shall maintain the confidentiality of any information found by the commissioner to be the proprietary information of the insurer.

(o) This section shall become operative on July 1, 2015.

(p) This section shall remain in effect only until January 1, 2017, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2017, deletes or extends that date.

SEC. 19. Section 10169 is added to the Insurance Code, to read:

10169. (a) Commencing January 1, 2001, there is hereby established in the department the Independent Medical Review System.

(b) For the purposes of this chapter, "disputed health care service" means any health care service eligible for coverage and payment under a disability insurance contract that has been denied, modified, or delayed by a decision of the insurer, or by one of its contracting providers, in whole or in part due to a finding that the service is not medically necessary. A decision regarding a disputed health care service relates to the practice of medicine and is not a coverage decision. A disputed health care service does not include services provided by a group or individual policy of vision-only or dental-only coverage, except to the extent that (1) the service involves the practice of medicine, or (2) is provided pursuant to a contract with a disability insurer that covers hospital, medical, or surgical benefits. If an insurer, or one of its contracting providers, issues a decision denying, modifying, or delaying health care services, based in whole or in part on a finding that the proposed health care services are not a covered benefit under the contract that applies to the insured, the statement of decision shall clearly specify the provision in the contract that excludes that coverage.

(c) For the purposes of this chapter, "coverage decision" means the approval or denial of health care services by a disability insurer, or by one of its contracting entities, substantially based on a finding that the provision of a particular service is included or excluded as a covered benefit under the terms and conditions of the disability insurance contract. A coverage decision does not encompass a disability insurer or contracting provider decision regarding a disputed health care service.

(d) (1) All insured grievances involving a disputed health care service are eligible for review under the Independent Medical Review System if the requirements of this article are met. If the department finds that an insured grievance involving a disputed health care service does not meet the requirements of this article for review under the Independent Medical Review System, the

insured request for review shall be treated as a request for the department to review the grievance. All other insured grievances, including grievances involving coverage decisions, remain eligible for review by the department.

(2) In any case in which an insured or provider asserts that a decision to deny, modify, or delay health care services was based, in whole or in part, on consideration of medical necessity, the department shall have the final authority to determine whether the grievance is more properly resolved pursuant to an independent medical review as provided under this article.

(3) The department shall be the final arbiter when there is a question as to whether an insured grievance is a disputed health care service or a coverage decision. The department shall establish a process to complete an initial screening of an insured grievance. If there appears to be any medical necessity issue, the grievance shall be resolved pursuant to an independent medical review as provided under this article.

(e) Every disability insurance contract that is issued, amended, renewed, or delivered in this state on or after January 1, 2000, shall provide an insured with the opportunity to seek an independent medical review whenever health care services have been denied, modified, or delayed by the insurer, or by one of its contracting providers, if the decision was based in whole or in part on a finding that the proposed health care services are not medically necessary. For purposes of this article, an insured may designate an agent to act on his or her behalf. The provider may join with or otherwise assist the insured in seeking an independent medical review, and may advocate on behalf of the insured.

(f) Medicare beneficiaries enrolled in Medicare + Choice products shall not be excluded unless expressly preempted by federal law.

(g) The department may seek to integrate the quality of care and consumer protection provisions, including remedies, of the Independent Medical Review System with related dispute resolution procedures of other health care agency programs, including the Medicare program, in a way that minimizes the potential for duplication, conflict, and added costs. Nothing in this subdivision shall be construed to limit any rights conferred upon insureds under this chapter.

(h) The independent medical review process authorized by this article is in addition to any other procedures or remedies that may be available.

(i) Every disability insurer shall prominently display in every insurer member handbook or relevant informational brochure, in every insurance contract, on insured evidence of coverage forms, on copies of insurer procedures for resolving grievances, on letters of denials issued by either the insurer or its contracting organization, and on all written responses to grievances, information concerning the right of an insured to request an independent medical review when the insured believes that health care services have been improperly denied, modified, or delayed by the insurer, or by one of its contracting providers. The department's telephone number, 1-800-927-4357, and Internet Web site, www.insurance.ca.gov, shall also be displayed.

(j) An insured may apply to the department for an independent medical review when all of the following conditions are met:

(1) (A) The insured's provider has recommended a health care service as medically necessary, or

(B) The insured has received urgent care or emergency services that a provider determined was medically necessary, or

(C) The insured, in the absence of a provider recommendation under subparagraph (A) or the receipt of urgent care or emergency services by a provider under subparagraph (B), has been seen by a contracting provider for the diagnosis or treatment of the medical condition for which the insured seeks independent review. The insurer shall expedite access to a contracting provider upon request of an insured. The contracting provider need not recommend the disputed health care service as a condition for the insured to be eligible for an independent review.

For purposes of this article, the insured's provider may be a noncontracting provider. However, the insurer shall have no liability for payment of services provided by a noncontracting provider, except as provided pursuant to Section 10169.3.

(2) The disputed health care service has been denied, modified, or delayed by the insurer, or by one of its contracting providers, based in whole or in part on a decision that the health care service is not medically necessary.

(3) The insured has filed a grievance with the insurer or its contracting provider, and the disputed decision is upheld or the

grievance remains unresolved after 30 days. The insured shall not be required to participate in the insurer's grievance process for more than 30 days. In the case of a grievance that requires expedited review, the insured shall not be required to participate in the insurer's grievance process for more than three days.

(k) An insured may apply to the department for an independent medical review of a decision to deny, modify, or delay health care services, based in whole or in part on a finding that the disputed health care services are not medically necessary, within six months of any of the qualifying periods or events under subdivision (j). The commissioner may extend the application deadline beyond six months if the circumstances of a case warrant the extension.

(*l*) The insured shall pay no application or processing fees of any kind.

(m) As part of its notification to the insured regarding a disposition of the insured's grievance that denies, modifies, or delays health care services, the insurer shall provide the insured with a one- or two-page application form approved by the department, and an addressed envelope, which the insured may return to initiate an independent medical review. The insurer shall include on the form any information required by the department to facilitate the completion of the independent medical review, such as the insured's diagnosis or condition, the nature of the disputed health care service sought by the insured, a means to identify the insured's case, and any other material information. The form shall also include the following:

(1) Notice that a decision not to participate in the independent review process may cause the insured to forfeit any statutory right to pursue legal action against the insurer regarding the disputed health care service.

(2) A statement indicating the insured's consent to obtain any necessary medical records from the insurer, any of its contracting providers, and any noncontracting provider the insured may have consulted on the matter, to be signed by the insured.

(3) Notice of the insured's right to provide information or documentation, either directly or through the insured's provider, regarding any of the following:

(A) A provider recommendation indicating that the disputed health care service is medically necessary for the insured's medical condition.

(B) Medical information or justification that a disputed health care service, on an urgent care or emergency basis, was medically necessary for the insured's medical condition.

(C) Reasonable information supporting the insured's position that the disputed health care service is or was medically necessary for the insured's medical condition, including all information provided to the insured by the insurer or any of its contracting providers, still in the possession of the insured, concerning an insurer or provider decision regarding disputed health care services, and a copy of any materials the insured submitted to the insurer, still in the possession of the insured, in support of the grievance, as well as any additional material that the insured believes is relevant.

(4) A section designed to collect information on the insured's ethnicity, race, and primary language spoken that includes both of the following:

(A) A statement of intent indicating that the information is used for statistics only, in order to ensure that all insureds get the best care possible.

(B) A statement indicating that providing this information is optional and will not affect the independent medical review process in any way.

(n) Upon notice from the department that the insured has applied for an independent medical review, the insurer or its contracting providers, shall provide to the independent medical review organization designated by the department a copy of all of the following documents within three business days of the insurer's receipt of the department's notice of a request by an insured for an independent review:

(1) (A) A copy of all of the insured's medical records in the possession of the insurer or its contracting providers relevant to each of the following:

(i) The insured's medical condition.

(ii) The health care services being provided by the insurer and its contracting providers for the condition.

(iii) The disputed health care services requested by the insured for the condition.

(B) Any newly developed or discovered relevant medical records in the possession of the insurer or its contracting providers after the initial documents are provided to the independent medical

review organization shall be forwarded immediately to the independent medical review organization. The insurer shall concurrently provide a copy of medical records required by this subparagraph to the insured or the insured's provider, if authorized by the insured, unless the offer of medical records is declined or otherwise prohibited by law. The confidentiality of all medical record information shall be maintained pursuant to applicable state and federal laws.

(2) A copy of all information provided to the insured by the insurer and any of its contracting providers concerning insurer and provider decisions regarding the insured's condition and care, and a copy of any materials the insured or the insured's provider submitted to the insurer and to the insurer's contracting providers in support of the insured's request for disputed health care services. This documentation shall include the written response to the insured's grievance. The confidentiality of any insured medical information shall be maintained pursuant to applicable state and federal laws.

(3) A copy of any other relevant documents or information used by the insurer or its contracting providers in determining whether disputed health care services should have been provided, and any statements by the insurer and its contracting providers explaining the reasons for the decision to deny, modify, or delay disputed health care services on the basis of medical necessity. The insurer shall concurrently provide a copy of documents required by this paragraph, except for any information found by the commissioner to be legally privileged information, to the insured and the insured's provider. The department and the independent medical review organization shall maintain the confidentiality of any information found by the commissioner to be the proprietary information of the insurer.

(o) This section shall become operative on January 1, 2017.

SEC. 20. Section 10192.18 of the Insurance Code is amended to read:

10192.18. (a) Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant currently has Medicare supplement, Medicare Advantage, Medi-Cal coverage, or another health insurance policy or certificate in force or whether a Medicare supplement policy or certificate is intended to replace any other

disability policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and agent containing those questions and statements may be used.

(Statements)

(1) You do not need more than one Medicare supplement policy.

(2) If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

(3) You may be eligible for benefits under Medi-Cal and may not need a Medicare supplement policy.

(4) If after purchasing this policy you become eligible for Medi-Cal, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medi-Cal for 24 months. You must request this suspension within 90 days of becoming eligible for Medi-Cal. If you are no longer entitled to Medi-Cal, your suspended Medicare supplement policy or if that is no longer available, a substantially equivalent policy, will be reinstituted if requested within 90 days of losing Medi-Cal eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

(5) If you are eligible for, and have enrolled in, a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances and later lose your employer or union-based group health plan, your suspended Medicare supplement policy or if that is no longer available, a substantially equivalent policy, will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted

policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

(6) Counseling services are available in this state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the Medi-Cal program, including benefits as a qualified Medicare beneficiary (QMB) and a specified low-income Medicare beneficiary (SLMB). If you want to discuss buying Medicare supplement insurance with a trained insurance counselor, call the California Department of Insurance's toll-free telephone number 1-800-927-HELP, and ask how to contact your local Health Insurance Counseling and Advocacy Program (HICAP) office. HICAP is a service provided free of charge by the State of California.

(Questions)

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application. PLEASE ANSWER ALL QUESTIONS.

[Please mark Yes or No below with an "X."]

To the best of your knowledge,

(1) (a) Did you turn 65 years of age in the last 6 months.

Yes____ No____

(b) Did you enroll in Medicare Part B in the last 6 months.

Yes____ No____

(c) If yes, what is the effective date. _____

(2) Are you covered for medical assistance through California's Medi-Cal program.

NOTE TO APPLICANT: If you have a share of cost under the Medi-Cal program, please answer NO to this question.

Yes____ No____

If yes,

(a) Will Medi-Cal pay your premiums for this Medicare supplement policy.

Yes____ No____

(b) Do you receive benefits from Medi-Cal OTHER THAN payments toward your Medicare Part B premium.

Yes____ No____

(3) (a) If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.

START __/__/__ END __/__/__

(b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy.

Yes____ No____

(c) Was this your first time in this type of Medicare plan.

Yes____ No____

(d) Did you drop a Medicare supplement policy to enroll in the Medicare plan.

Yes____ No____

(4) (a) Do you have another Medicare supplement policy in force.

Yes____ No____

(b) If so, with what company, and what plan do you have. [optional for direct mailers]

Yes____ No____

(c) If so, do you intend to replace your current Medicare supplement policy with this policy.

Yes____ No____

(5) Have you had coverage under any other health insurance within the past 63 days (For example, an employer, union, or individual plan).

Yes____ No____

(a) If so, with what companies and what kind of policy.

_____

_____

_____

_____

(b) What are your dates of coverage under the other policy.

START __/__/__ END __/__/__

(If you are still covered under the other policy, leave "END" blank.)

(b) Agents shall list any other health insurance policies they have sold to the applicant as follows:

(1) List policies sold that are still in force.

(2) List policies sold in the past five years that are no longer in force.

(c) In the case of a direct response issuer, a copy of the application or supplemental form, signed by the applicant, and acknowledged by the issuer, shall be returned to the applicant by the issuer upon delivery of the policy.

(d) Upon determining that a sale will involve replacement of Medicare supplement coverage, any issuer, other than a direct response issuer, or its agent, shall furnish the applicant, prior to issuance for delivery of the Medicare supplement policy or certificate, a notice regarding replacement of Medicare supplement coverage. One copy of the notice signed by the applicant and the agent, except when the coverage is sold without an agent, shall be provided to the applicant and an additional signed copy shall be retained by the issuer as provided in Section 10508. A direct response issuer shall deliver to the applicant at the time of the issuance of the policy the notice regarding replacement of Medicare supplement coverage.

(e) The notice required by subdivision (d) for an issuer shall be in the form specified by the commissioner, using, to the extent practicable, a model notice prepared by the National Association of Insurance Commissioners for this purpose. The replacement notice shall be printed in no less than 12-point type in substantially the following form:

[Insurer’s name and address]

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT COVERAGE OR MEDICARE ADVANTAGE

SAVE THIS NOTICE! IT MAY BE IMPORTANT IN THE FUTURE.

If you intend to cancel or terminate existing Medicare supplement or Medicare Advantage insurance and replace it with coverage issued by [company name], please review the new coverage

carefully and replace the existing coverage ONLY if the new coverage materially improves your position. DO NOT CANCEL YOUR PRESENT COVERAGE UNTIL YOU HAVE RECEIVED YOUR NEW POLICY AND ARE SURE THAT YOU WANT TO KEEP IT.

If you decide to purchase the new coverage, you will have 30 days after you receive the policy to return it to the insurer, for any reason, and receive a refund of your money.

If you want to discuss buying Medicare supplement or Medicare Advantage coverage with a trained insurance counselor, call the California Department of Insurance's toll-free telephone number 1-800-927-HELP, and ask how to contact your local Health Insurance Counseling and Advocacy Program (HICAP) office. HICAP is a service provided free of charge by the State of California.

STATEMENT TO APPLICANT FROM THE INSURER AND AGENT: I have reviewed your current health insurance coverage. To the best of my knowledge, the replacement of insurance involved in this transaction does not duplicate coverage or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan. In addition, the replacement coverage contains benefits that are clearly and substantially greater than your current benefits for the following reasons:

__ Additional benefits that are: _____

__ No change in benefits, but lower premiums.

__ Fewer benefits and lower premiums.

__ Plan has outpatient prescription drug coverage and applicant is enrolled in Medicare Part D.

__ Disenrollment from a Medicare Advantage plan. Reasons for disenrollment:

__ Other reasons specified here: _____

1. Note: If the issuer of the Medicare supplement policy being applied for does not impose, or is otherwise prohibited from imposing, preexisting condition limitations, please skip to statement 3 below. Health conditions that you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement Medicare supplement policy may not contain new preexisting conditions, waiting periods, elimination periods, or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new coverage for similar benefits to the extent that time was spent (depleted) under the original policy.

3. If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer any and all questions on the application concerning your medical and health history. Failure to include all material medical information on an application requesting that information may provide a basis for the insurer to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

DO NOT CANCEL YOUR PRESENT POLICY UNTIL YOU HAVE RECEIVED YOUR NEW POLICY AND ARE SURE THAT YOU WANT TO KEEP IT.

_____

(Signature of Agent, Broker, or Other Representative)

_____

(Signature of Applicant)

_____

(Date)

(f) No issuer, broker, agent, or other person shall cause an insured to replace a Medicare supplement insurance policy unnecessarily. In recommending replacement of any Medicare supplement insurance, an agent shall make reasonable efforts to determine the appropriateness to the potential insured.

(g) An issuer shall not require, request, or obtain health information as part of the application process for an applicant who is eligible for guaranteed issuance of, or open enrollment for, any Medicare supplement coverage pursuant to Section 10192.11 or 10192.12, except for purposes of paragraph (1) or (2) of subdivision (a) of Section 10192.11 when the applicant is first enrolled in

Medicare Part B. The application form shall include a clear and conspicuous statement that the applicant is not required to provide health information during a period where guaranteed issue or open enrollment applies, as specified in Section 10192.11 or 10192.12, except for purposes of paragraph (1) or (2) of subdivision (a) of Section 10192.11 when the applicant is first enrolled in Medicare Part B, and shall inform the applicant of those periods of guaranteed issuance of Medicare supplement coverage. This subdivision shall not prohibit an issuer from requiring proof of eligibility for a guaranteed issuance of Medicare supplement coverage.

(h) This section shall remain in effect only until January 1, 2017, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2017, deletes or extends that date.

SEC. 21. Section 10192.18 is added to the Insurance Code, to read:

10192.18. (a) Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant currently has Medicare supplement, Medicare Advantage, Medi-Cal coverage, or another health insurance policy or certificate in force or whether a Medicare supplement policy or certificate is intended to replace any other disability policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and agent containing those questions and statements may be used.

(Statements)

(1) You do not need more than one Medicare supplement policy.

(2) If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

(3) You may be eligible for benefits under Medi-Cal and may not need a Medicare supplement policy.

(4) If after purchasing this policy you become eligible for Medi-Cal, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medi-Cal for 24 months. You must request this suspension within 90 days of becoming eligible for Medi-Cal. If you are no longer entitled to Medi-Cal, your suspended Medicare supplement policy or if that is no longer

available, a substantially equivalent policy, will be reinstituted if requested within 90 days of losing Medi-Cal eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

(5) If you are eligible for, and have enrolled in, a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances and later lose your employer or union-based group health plan, your suspended Medicare supplement policy or if that is no longer available, a substantially equivalent policy, will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

(6) Counseling services are available in this state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the Medi-Cal program, including benefits as a qualified Medicare beneficiary (QMB) and a specified low-income Medicare beneficiary (SLMB). If you want to discuss buying Medicare supplement insurance with a trained insurance counselor, call the California Department of Insurance's toll-free telephone number 1-800-927-HELP, or access the department's Internet Web site, www.insurance.ca.gov, and ask how to contact your local Health Insurance Counseling and Advocacy Program (HICAP) office. HICAP is a service provided free of charge by the State of California.

(Questions)

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application. PLEASE ANSWER ALL QUESTIONS.

[Please mark Yes or No below with an "X."]

To the best of your knowledge,

(1) (a) Did you turn 65 years of age in the last 6 months.

Yes____ No____

(b) Did you enroll in Medicare Part B in the last 6 months.

Yes____ No____

(c) If yes, what is the effective date. _____

(2) Are you covered for medical assistance through California's Medi-Cal program.

NOTE TO APPLICANT: If you have a share of cost under the Medi-Cal program, please answer NO to this question.

Yes____ No____

If yes,

(a) Will Medi-Cal pay your premiums for this Medicare supplement policy.

Yes____ No____

(b) Do you receive benefits from Medi-Cal OTHER THAN payments toward your Medicare Part B premium.

Yes____ No____

(3) (a) If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.

START __/__/__ END __/__/__

(b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy.

Yes____ No____

(c) Was this your first time in this type of Medicare plan.

Yes____ No____

(d) Did you drop a Medicare supplement policy to enroll in the Medicare plan.

Yes____ No____

(4) (a) Do you have another Medicare supplement policy in force.

Yes____ No____

(b) If so, with what company, and what plan do you have. [optional for direct mailers]

Yes____ No____

(c) If so, do you intend to replace your current Medicare supplement policy with this policy.

Yes____ No____

(5) Have you had coverage under any other health insurance within the past 63 days (For example, an employer, union, or individual plan).

Yes____ No____

(a) If so, with what companies and what kind of policy.

_____

_____

_____

_____

(b) What are your dates of coverage under the other policy.

START __/__/__ END __/__/__

(If you are still covered under the other policy, leave "END" blank.)

(b) Agents shall list any other health insurance policies they have sold to the applicant as follows:

(1) List policies sold that are still in force.

(2) List policies sold in the past five years that are no longer in force.

(c) In the case of a direct response issuer, a copy of the application or supplemental form, signed by the applicant, and acknowledged by the issuer, shall be returned to the applicant by the issuer upon delivery of the policy.

(d) Upon determining that a sale will involve replacement of Medicare supplement coverage, any issuer, other than a direct response issuer, or its agent, shall furnish the applicant, prior to issuance for delivery of the Medicare supplement policy or certificate, a notice regarding replacement of Medicare supplement coverage. One copy of the notice signed by the applicant and the agent, except when the coverage is sold without an agent, shall be

provided to the applicant and an additional signed copy shall be retained by the issuer as provided in Section 10508. A direct response issuer shall deliver to the applicant at the time of the issuance of the policy the notice regarding replacement of Medicare supplement coverage.

(e) The notice required by subdivision (d) for an issuer shall be in the form specified by the commissioner, using, to the extent practicable, a model notice prepared by the National Association of Insurance Commissioners for this purpose. The replacement notice shall be printed in no less than 12-point type in substantially the following form:

[Insurer's name and address]

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT COVERAGE OR MEDICARE ADVANTAGE

SAVE THIS NOTICE! IT MAY BE IMPORTANT IN THE FUTURE.

If you intend to cancel or terminate existing Medicare supplement or Medicare Advantage insurance and replace it with coverage issued by [company name], please review the new coverage carefully and replace the existing coverage ONLY if the new coverage materially improves your position. DO NOT CANCEL YOUR PRESENT COVERAGE UNTIL YOU HAVE RECEIVED YOUR NEW POLICY AND ARE SURE THAT YOU WANT TO KEEP IT.

If you decide to purchase the new coverage, you will have 30 days after you receive the policy to return it to the insurer, for any reason, and receive a refund of your money.

If you want to discuss buying Medicare supplement or Medicare Advantage coverage with a trained insurance counselor, call the California Department of Insurance's toll-free telephone number 1-800-927-HELP, and ask how to contact your local Health Insurance Counseling and Advocacy Program (HICAP) office. HICAP is a service provided free of charge by the State of California.

STATEMENT TO APPLICANT FROM THE INSURER AND AGENT: I have reviewed your current health insurance coverage.

To the best of my knowledge, the replacement of insurance involved in this transaction does not duplicate coverage or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan. In addition, the replacement coverage contains benefits that are clearly and substantially greater than your current benefits for the following reasons:

__ Additional benefits that are: _____

__ No change in benefits, but lower premiums.

__ Fewer benefits and lower premiums.

__ Plan has outpatient prescription drug coverage and applicant is enrolled in Medicare Part D.

__ Disenrollment from a Medicare Advantage plan. Reasons for disenrollment:

__ Other reasons specified here: _____

1. Note: If the issuer of the Medicare supplement policy being applied for does not impose, or is otherwise prohibited from imposing, preexisting condition limitations, please skip to statement 3 below. Health conditions that you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement Medicare supplement policy may not contain new preexisting conditions, waiting periods, elimination periods, or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new coverage for similar benefits to the extent that time was spent (depleted) under the original policy.

3. If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer any and all questions on the application concerning your medical and health history. Failure to include all material medical information on an application requesting that information may provide a basis for the insurer to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has

been properly recorded. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

DO NOT CANCEL YOUR PRESENT POLICY UNTIL YOU HAVE RECEIVED YOUR NEW POLICY AND ARE SURE THAT YOU WANT TO KEEP IT.

_____

(Signature of Agent, Broker, or Other Representative)

_____

(Signature of Applicant)

_____

(Date)

(f) No issuer, broker, agent, or other person shall cause an insured to replace a Medicare supplement insurance policy unnecessarily. In recommending replacement of any Medicare supplement insurance, an agent shall make reasonable efforts to determine the appropriateness to the potential insured.

(g) An issuer shall not require, request, or obtain health information as part of the application process for an applicant who is eligible for guaranteed issuance of, or open enrollment for, any Medicare supplement coverage pursuant to Section 10192.11 or 10192.12, except for purposes of paragraph (1) or (2) of subdivision (a) of Section 10192.11 when the applicant is first enrolled in Medicare Part B. The application form shall include a clear and conspicuous statement that the applicant is not required to provide health information during a period where guaranteed issue or open enrollment applies, as specified in Section 10192.11 or 10192.12, except for purposes of paragraph (1) or (2) of subdivision (a) of Section 10192.11 when the applicant is first enrolled in Medicare Part B, and shall inform the applicant of those periods of guaranteed issuance of Medicare supplement coverage. This subdivision shall not prohibit an issuer from requiring proof of eligibility for a guaranteed issuance of Medicare supplement coverage.

(h) This section shall become operative on January 1, 2017.

SEC. 22. Section 10232.3 of the Insurance Code is amended to read:

10232.3. (a) All applications for long-term care insurance except that which is guaranteed issue, shall contain clear,

unambiguous, short, simple questions designed to ascertain the health condition of the applicant. Each question shall contain only one health status inquiry and shall require only a "yes" or "no" answer, except that the application may include a request for the name of any prescribed medication and the name of a prescribing physician. If the application requests the name of any prescribed medication or prescribing physician, then any mistake or omission shall not be used as a basis for the denial of a claim or the rescission of a policy or certificate.

(b) The following warning shall be printed conspicuously and in close conjunction with the applicant's signature block:

"Caution: If your answers on this application are misstated or untrue, the insurer may have the right to deny benefits or rescind your coverage."

(c) Every application for long-term care insurance shall include a checklist that enumerates each of the specific documents that this chapter requires be given to the applicant at the time of solicitation. The documents and notices to be listed in the checklist include, but are not limited to, the following:

(1) The outline of coverage pursuant to Section 10233.5.

(2) The HICAP notice pursuant to paragraph (8) of subdivision (a) of Section 10234.93.

(3) The long-term care insurance shoppers guide pursuant to paragraph (9) of subdivision (a) of Section 10234.93.

(4) The "Long-Term Care Insurance Personal Worksheet" pursuant to subdivision (c) of Section 10234.95.

(5) The "Notice to Applicant Regarding Replacement of Accident and Sickness or Long-Term Care Insurance" pursuant to Section 10235.16 if replacement is not made by direct response solicitation or Section 10235.18 if replacement is made by direct response solicitation. Unless the solicitation was made by a direct response method, the agent and applicant shall both sign at the bottom of the checklist to indicate the required documents were delivered and received.

(d) If an insurer does not complete medical underwriting and resolve all reasonable questions arising from information submitted on or with an application before issuing the policy or certificate, then the insurer may only rescind the policy or certificate or deny an otherwise valid claim, upon clear and convincing evidence of

fraud or material misrepresentation of the risk by the applicant. The evidence shall:

(1) Pertain to the condition for which benefits are sought.

(2) Involve a chronic condition or involve dates of treatment before the date of application.

(3) Be material to the acceptance for coverage.

(e) No long-term care policy or certificate may be field issued.

(f) The contestability period as defined in Section 10350.2 for long-term care insurance shall be two years.

(g) A copy of the completed application shall be delivered to the insured at the time of delivery of the policy or certificate.

(h) Every insurer shall maintain a record, in accordance with Section 10508, of all policy or certificate rescissions, both state and countrywide, and shall annually furnish this information to the commissioner, which shall include the reason for rescission, the length of time the policy or certificate was in force, and the age and gender of the insured person, in a format prescribed by the commissioner.

(i) The commissioner may, in his or her discretion, make public the aggregate data collected under subdivision (h), upon request.

SEC. 23. Section 10233.9 of the Insurance Code is repealed.

SEC. 24. Section 10235.35 of the Insurance Code is amended to read:

10235.35. (a) Notwithstanding any other law, the commissioner may require the administration by an insurer of the contingent benefit upon lapse, as described in Section 28 (A), (D) (3), (E), (F), (G), and (J) of the Long-Term Care Insurance Model Regulation promulgated by the National Association of Insurance Commissioners, as adopted in September 2014, as a condition of approval or acknowledgment of a rate adjustment for a block of business for which the contingent benefit upon lapse is not otherwise available.

(b) The insurer shall notify policyholders and certificate holders of the contingent benefit upon lapse when required by the commissioner in conjunction with the implementation of a rate adjustment. The commissioner may require an insurer who files for such a rate adjustment to allow policyholders and certificate holders to reduce coverage pursuant to Section 10235.50 to avoid an increase in the policy’s premium amount.

(c) The commissioner may also approve any other alternative mechanism filed by the insurer in lieu of the contingent benefit upon lapse.

SEC. 25. Section 12418.4 of the Insurance Code is amended to read:

12418.4. (a) Sections 1667, 1668, 1669, 1670, 1729, 1729.2, 1738, 1738.5, 1743, and Article 6 (commencing with Section 12404), shall apply to all applicants or holders of a certificate of registration issued pursuant to this article.

(b) The department may revoke, suspend, restrict, or decline to issue a certificate of registration if it determines that the title marketing representative or applicant has violated provisions of Article 6 (commencing with Section 12404) pursuant to the due process and hearing requirements set forth in subdivision (c).

(c) Except as provided in Section 1669, a certificate of registration shall not be denied, restricted, suspended, or revoked without a hearing conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

(d) In addition to, or in lieu of, any other penalty that may be imposed under this article against a title marketing representative, the commissioner may bring an administrative action against a title marketing representative for any violation of the provisions of Article 6 (commencing with Section 12404). If a title marketing representative charged with a violation of Article 6 (commencing with Section 12404) is determined by the commissioner to have committed the violation, the commissioner may require the surrender of, temporarily suspend or revoke either permanently or temporarily the title marketing representative's certificate of registration, and, in addition, may impose a monetary penalty. Any payment of a monetary penalty pursuant to a settlement or final adjudication shall be made from the title marketing representative's personal funds and not by his or her employer either directly or through the title marketing representative. This article shall not preclude an action against a company that had actual knowledge of the violation by the title marketing representative. A title marketing representative who is issued a certificate of registration under this article may not engage in any activity that is otherwise prohibited through a separate entity controlled by the title

marketing representative or by the company or entity that employs him or her.

(e) A title marketing representative who has his or her certificate of registration revoked by the department shall not be permitted to reapply for another certificate of registration with the department for five years from the date of revocation.

SEC. 26. Section 12820 of the Insurance Code is amended to read:

12820. (a) Prior to offering a vehicle service contract form to a purchaser or providing a vehicle service contract form to a seller, an obligor shall file with the commissioner a specimen of that vehicle service contract form.

(b) A vehicle service contract form may include any or all of the benefits described in subdivision (c) of Section 12800 and shall comply with all of the following requirements:

(1) (A) If an obligor has complied with Section 12830, the vehicle service contract shall include a disclosure in substantially the following form: "Performance to you under this contract is guaranteed by a California approved insurance company. You may file a claim with this insurance company if any promise made in the contract has been denied or has not been honored within 60 days after your request. The name and address of the insurance company is: (insert name and address). If you are not satisfied with the insurance company's response, you may contact the California Department of Insurance at 1-800-927-4357."

(B) If an obligor has complied with Section 12836, the vehicle service contract shall include a disclosure in substantially the following form: "If any promise made in the contract has been denied or has not been honored within 60 days after your request, you may contact the California Department of Insurance at 1-800-927-4357."

(2) All vehicle service contract language that excludes coverage, or imposes duties upon the purchaser, shall be conspicuously printed in boldface type no smaller than the surrounding type.

(3) The vehicle service contract shall do each of the following:

(A) State the obligor's full corporate name or a fictitious name approved by the commissioner, the obligor's mailing address, the obligor's telephone number, and the obligor's vehicle service contract provider license number.

(B) State the name of the purchaser and the name of the seller.

(C) Conspicuously state the vehicle service contract's purchase price.

(D) Comply with Sections 1794.4 and 1794.41 of the Civil Code.

(E) Name the administrator, if any, and provide the administrator's license number.

(4) If the vehicle service contract excludes coverage for preexisting conditions, the contract must disclose this exclusion in 12-point type.

(c) The following benefits constitute insurance, whether offered as part of a vehicle service contract or in a separate agreement:

(1) Indemnification for a loss caused by misplacement, theft, collision, fire, or other peril typically covered in the comprehensive coverage section of an automobile insurance policy, a homeowner's policy, or a marine or inland marine policy.

(2) Locksmith services, unless offered as part of an emergency road service benefit.

(d) This section shall remain in effect only until January 1, 2017, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2017, deletes or extends that date.

SEC. 27. Section 12820 is added to the Insurance Code, to read:

12820. (a) Prior to offering a vehicle service contract form to a purchaser or providing a vehicle service contract form to a seller, an obligor shall file with the commissioner a specimen of that vehicle service contract form.

(b) A vehicle service contract form may include any or all of the benefits described in subdivision (c) of Section 12800 and shall comply with all of the following requirements:

(1) (A) If an obligor has complied with Section 12830, the vehicle service contract shall include a disclosure in substantially the following form: "Performance to you under this contract is guaranteed by a California approved insurance company. You may file a claim with this insurance company if any promise made in the contract has been denied or has not been honored within 60 days after your request. The name and address of the insurance company is: (insert name and address). If you are not satisfied with the insurance company's response, you may contact the California Department of Insurance at 1-800-927-4357 or access the department's Internet Web site (www.insurance.ca.gov)."

(B) If an obligor has complied with Section 12836, the vehicle service contract shall include a disclosure in substantially the following form: “If any promise made in the contract has been denied or has not been honored within 60 days after your request, you may contact the California Department of Insurance at 1-800-927-4357 or access the department’s Internet Web site (www.insurance.ca.gov).”

(C) The requirement that a vehicle service contract form include the department’s Internet Web site shall not apply to a form for which the department has issued a “no objection letter” as of December 31, 2016.

(2) All vehicle service contract language that excludes coverage, or imposes duties upon the purchaser, shall be conspicuously printed in boldface type no smaller than the surrounding type.

(3) The vehicle service contract shall do each of the following:

(A) State the obligor’s full corporate name or a fictitious name approved by the commissioner, the obligor’s mailing address, the obligor’s telephone number, and the obligor’s vehicle service contract provider license number.

(B) State the name of the purchaser and the name of the seller.

(C) Conspicuously state the vehicle service contract’s purchase price.

(D) Comply with Sections 1794.4 and 1794.41 of the Civil Code.

(E) Name the administrator, if any, and provide the administrator’s license number.

(4) If the vehicle service contract excludes coverage for preexisting conditions, the contract must disclose this exclusion in 12-point type.

(c) The following benefits constitute insurance, whether offered as part of a vehicle service contract or in a separate agreement:

(1) Indemnification for a loss caused by misplacement, theft, collision, fire, or other peril typically covered in the comprehensive coverage section of an automobile insurance policy, a homeowner’s policy, or a marine or inland marine policy.

(2) Locksmith services, unless offered as part of an emergency road service benefit.

(d) This section shall become operative on January 1, 2017.

SEC. 28. Section 12921 of the Insurance Code is amended to read:

12921. (a) The commissioner shall perform all duties imposed upon him or her by the provisions of this code and other laws regulating the business of insurance in this state, and shall enforce the execution of those provisions and laws.

(b) In an administrative action to enforce the provisions of this code and other laws regulating the business of insurance in this state, any settlement is subject to all of the following:

(1) The commissioner may delegate the power to negotiate the terms and conditions of a settlement to designated deputy commissioners. The commissioner may delegate the power to approve a settlement, unless the settlement involves any of the following:

(A) An insurer.

(B) A managing general agent or production agent that manages the business of an insurer.

(C) A title company.

(D) A home protection company.

(E) An insurance adjuster whose claims practices are at issue.

(F) An insurance agent or broker, or an applicant for an insurance agent or broker license, who has allegedly engaged in theft, fraud, or the misappropriation of premium or other funds in an amount that exceeds fifty thousand dollars ($50,000).

(2) Unless specifically provided for in a provision of this code, the commissioner may not agree to any of the following:

(A) That the respondent contribute, deposit, or transfer any moneys or other resources to a nonprofit entity.

(B) That a respondent contribute, deposit, or transfer any fine, penalty, assessment, cost, or fee except to the commissioner for deposit in the appropriate state fund pursuant to Section 12975.7.

(C) That the commissioner may or shall direct the transfer, distribution, or payment to another person or entity of any fine, penalty, assessment, cost, or fee.

(D) The use of the commissioner’s name, likeness, or voice in any printed material or audio or visual medium, either for general distribution or for distribution to specific recipients.

(3) The commissioner may only agree to payment to those persons or entities to whom payment may be due because of the respondent’s violation of a provision of this code or other law regulating the business of insurance in this state.

(4) A settlement may only include the sanctions provided by this code or other laws regulating the business of insurance in this state, except that the settlement may include attorney's fees, costs of the department in bringing the enforcement action, and future costs of the department to ensure compliance with the settlement agreement.

(c) Notwithstanding any other provision of law, the commissioner may accept documents submitted for filing or approval, process transactions, and maintain records in electronic form or as paper documents, and may adopt regulations to further this subdivision.

SEC. 29. Section 1299.04 of the Penal Code is amended to read:

1299.04. (a) A bail fugitive recovery person, a bail agent, bail permittee, or bail solicitor who contracts his or her services to another bail agent or surety as a bail fugitive recovery person for the purposes specified in subdivision (d) of Section 1299.01, and any bail agent, bail permittee, or bail solicitor who obtains licensing after January 1, 2000, and who engages in the arrest of a defendant pursuant to Section 1301 shall comply with the following requirements:

(1) The person shall be at least 18 years of age.

(2) The person shall have completed a 40-hour power of arrest course certified by the Commission on Peace Officer Standards and Training pursuant to Section 832. Completion of the course shall be for educational purposes only and not intended to confer the power of arrest of a peace officer or public officer, or agent of any federal, state, or local government, unless the person is so employed by a governmental agency.

(3) The person shall have completed a minimum of 20 hours of classroom prelicensing education certified pursuant to Section 1810.7 of the Insurance Code. For those persons licensed by the department as a bail licensee prior to January 1, 1994, there is no prelicensing education requirement. For those persons licensed by the department as a bail licensee between January 1, 1994, and December 31, 2012, a minimum of 12 hours of classroom prelicensing education is required.

(4) The person shall not have been convicted of a felony, unless the person is licensed by the Department of Insurance pursuant to Section 1800 of the Insurance Code.

(b) Upon completion of any course or training program required by this section, an individual authorized by Section 1299.02 to apprehend a bail fugitive shall carry certificates of completion with him or her at all times in the course of performing his or her duties under this article.

Approved _____, 2015

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Governor